WEST BANK/GAZA

CONTINUING HEALTH EDUCATION, RE-LICENSING AND ACCREDITATION

PALESTINIAN HEALTH SECTOR REFORM AND DEVELOPMENT PROJECT (THE FLAGSHIP PROJECT)

SHORT-TERM TECHNICAL ASSISTANCE REPORT – (FINAL)

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Contract No. 294-C-00-08-00225-00

Final submitted February 12, 2010

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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ACRONYMS

AACME – American Academy of Continuing Medical Education
AAFP – American Academy of Family Physicians
AAMC – Association of American Medical Colleges
ABIM – American Board of Internal Medicine
ACCME – Accreditation Council for Continuing Medical Education
ACGME – American Council for Graduate Medical Education Accreditation
ACHSI – Australian Council for Healthcare Standards International
ACP/ASIM – American College of Physicians/American Society of Internal Medicine
AMA – American Medical Association
CAHPE – Continuing Allied Health Professionals Education
CCHSA – Canadian Council on Health Services Accreditation
CDE – Continuing Dental Education
CHE – Continuing Health Education
CME – Continuing Medical Education
CNE – Continuing Nursing Education
CPD – Continuing Professional Development
CPE – Continuing Pharmacy Education
DHS – Demographic & Health Survey
GP – General Practitioner
HCAC – Health Care Accreditation Council
HRDD – Human Resources Development Department
HRMD – Human Resources Management Division
IDP – Institutional Development Plan
IMC - Israeli Medical Council
ISQua – International Society for Quality in Health Care
JCI – Joint Commission International
JD – Jordanian Dinar
LCME – Liaison Committee on Medical Education
MoH – Ministry of Health
NGO – Non-governmental Organization
OPE/USDE – Office of Postsecondary Education, US Department of Education
PHC – Primary Health Care
PHFAC – Palestinian Health Facility Accreditation Commission
PMC – Palestinian Medical Council
QI – Quality Improvement
SACME – Society for Academic Continuing Medical Education
UNRWA – United Nations Relief and Works Agency
USAID – US Agency for International Development

SECTION I: INTRODUCTION

The Flagship Project is a five-year initiative funded by the U.S. Agency for International Development (USAID), designed and implemented in collaboration with the Palestinian Ministry of Health (MoH). The Project's main objective is to support the MoH, selected non-governmental organizations, and selected educational and professional institutions in strengthening their institutional capacities and performance to support a functional and democratic Palestinian health sector able to meet its priority public health needs. The Project works to achieve this goal through three components: (1) supporting health sector reform and management, (2) strengthening clinical and community-based health, and (3) supporting procurement of health and humanitarian assistance commodities.

The MoH and Flagship Project are jointly committed to progress in continuing health education, accreditation, and relicensing. It is understood that the areas are linked and interdependent and the approach to developing them should reflect that interdependence. It was decided to engage the services of a single consultant to address the planning and feasibility issues of the three areas simultaneously. The consultant was expected to review current status in the three areas, assess the prospects for progress, and draft a strategy/plan for reaching the goals stated in the Institutional Development Plan. From the ToR, ". . . to act as the focal point in planning the overall national strategy and direction for the planning of these tasks over the next four years."

The in-going expectation was that leaders in the health sector would endorse the value of accreditation, increased CHE and mandatory re-licensing, but they would be cautious, if not pessimistic, about the prospects for making headway on these issues, especially mandatory re-licensing. This underscored the need to pick up the work on gauging readiness. While the formal tool adapted earlier might not be appropriate for use in interviews, the spirit of those lines of inquiry would be respected in order to map out sources of support for and resistance to policy change in the three areas. This necessarily imperfect survey of the positions of leaders in the sector would contribute an important dimension to any plan that might be drafted: political feasibility.

This consultancy also contributed to the following three modules of the MoH Institutional Development Plan (IDP):

Module 4: Design and implement a continuous education program for health professionals;

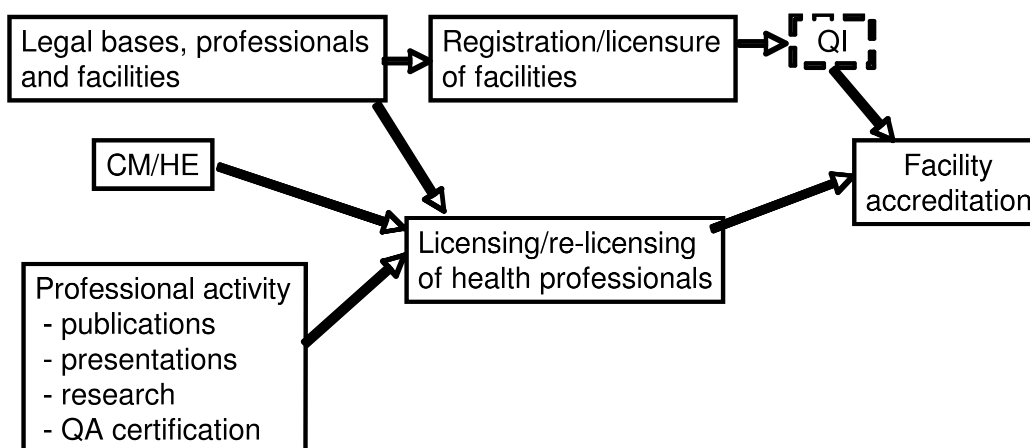
Module 5: Create and implement a re-licensing system for health professionals;

Module 6: Design and implement a health facility accreditation program.

SECTION II: BACKGROUND

Strengthened delivery capacity and policy reform intersect at many points, most clearly in the opportunities and requirements to increase the skills of providers and the quality of service facilities. Provider skills are maintained and professional currency ensured through educational programs that range form formal to self-initiated. Increasingly, the move has been to legislate mandatory requirements on practitioners to participate in continuing health education (CHE) programs; the very powerful incentive for participation in CHE is threat of loss of license to practice. Regarding facility quality, a basic standard is usually assured through government licensing requirements; higher standards of quality are typically pursued through successful participation in accreditation programs.

There are direct relationships among continuing health education, re-licensing of health professionals, and accreditation of healthcare facilities as illustrated in the following graphic:



Working backwards, from the right, facility accreditation typically requires:

- A functioning quality improvement program, although this can be created during the accrediting process (surrounded by dashed lines to signal its provisional status).
- Specifications on the kind and number of licensed professionals required in the facility.
- Minimum requirements set by the state for issuing a healthcare license to open its doors.

Note again the difference between a license to operate which only certifies that the facility has met minimum requirements – in effect has the *capacity* to deliver healthcare services – and accreditation which comes closer to assessing the *quality* of the services delivered. In The Palestinian health sector, the Licensing and Accreditation Unit of the MoH has been involved in providing only the basic license to operate, and has not conducted the more detailed examination of service delivery that would be associated with accreditation.

Working backward from licensing/re-licensing of health professionals in the above graphic, there are two general preconditions:

- Evidence of professional improvement, which may take the form of courses – continuing medical/health education – or other professional activity such as re-

search and publication, presentations, or other evidence of effort to maintain professional currency.

- Some form of state or school provided certificate which rests on attainment of minimum qualifications.

These three – CM/HE, licensing and accreditation – are linked, but they can be examined separately. Although the graphic would suggest that they are sequential, in practice they are not, as there is often scope to work on them simultaneously. To illustrate the point: there is no need to halt progress toward accreditation because the threshold number of re-licensed clinicians has not been passed; if the facility is working on re-licensing of clinicians the accrediting authority can issue a conditional accreditation, the condition being that the re-licensing standard is met in a determined period.

<u>The Palestinian health sector</u>. In professional competence and facility quality, the Palestinian health sector presents a mixed picture. Physicians and other healthcare providers are licensed to practice for life. There are nominal re-licensing procedures but no professional requirements are attached to these. In recent years the Palestinian Medical Council (PMC) has introduced stricter standards before recommending recent medical graduates to the MoH for licensing and awarding licenses to practice a specialty; these moves to a higher standard have been widely applauded.

Unfortunately, these higher standards apply only to new entrants into the health care workforce, and they are applied only once, at the start of the healthcare workers career. Left unresolved are questions concerning the quality of care provided by practitioners licensed several years ago, and whether, in the absence of mandatory requirements, healthcare workers take the initiative to remain current in their respective fields. Not surprisingly, there is skepticism about the latter and deep concern about the former. One reason for this concern is rooted in the wide and inconsistent sources of medical graduates. On the positive side, many physicians earn board certification in the US or UK, assiduously read the literature in their field, and take pride in the quality of service they provide. Unhappily, there are other medical graduates who come from weak academic and clinical programs – often in Eastern Europe or private medical schools in Egypt – and whose preparation may be less rigorous. As an example, the PMC recently failed every medical graduate from an Eastern European country.

In light of these disparities, and to raise the level of service quality in general, the MoH included the following three modules in the Institutional Development Plan:

Module 4: Design and implement a continuous education program for health professionals;

Module 5: Create and implement a re-licensing system for health professionals;

Module 6: Design and implement a health facility accreditation program.

There are antecedents in the health sector for modules 4 and 6. Health education programs have been available – and availed of – in a wide range of health areas. Some of these have been driven by donor perceptions of need, some by the organizations themselves (e.g. UNRWA and Al-Makassad Hospital conduct an annual refresher training program for staff), and individuals have sought out training opportunities, including the increasingly available e-learning courses. The government supports self-initiated learning activities within a limited scope. As examples: The MoH hospital in Hebron houses an e-learning lab for staff and MoH will reimburse 25 percent of the tuition for certain professionals seeking advanced degrees.

Regarding accreditation, no Palestinian hospital has sought accreditation from an international body such as the Joint Commission International, however, Al-Mukassad did apply for and receive ISO 2000 accreditation five years ago. Teaching programs within hospitals are accredited by the PMC and the standards applied are reportedly similar to those applied in an external accreditation survey. That noted, the focus of the PMC investigation is narrow: only the departments directly engaged in the teaching are surveyed; other departments/services in the same hospital may fall well below standards without imperiling the prospects of the department or service seeking accreditation as a training site.

Overlaying these disparities, and contributing to them, are the artifacts of Palestinian recent history. In the West Bank, the model and many on-going relationships, come from Jordan. In fact, the Palestinian Medical Association (the "Syndicate") is a district branch of the Jordan Medical Association, technically like Karak or Ajloun districts. The model for health policies and systems in Gaza is drawn from Egypt. The hospitals in Jerusalem find it necessary to comply with many Israeli provisions to remain eligible for referrals. This multiplicity of sometimes variant models has also fueled the impetus to define *national* policies on CHE, re-licensing and accreditation.

International/regional initiatives. Beyond the above cited antecedent activities in The Palestinian health sector, there are regional initiatives that influence thinking on the three areas, especially accreditation. Among the contiguous neighbors, Egypt has been at work on accreditation the longest, starting with accreditation of primary care facilities and later hospitals. The program was not limited to public sector facilities. Major Lebanese hospitals sought international accreditation, as did some of the leading hospitals in Jordan. A fledgling program in Jordan has gotten as far as developing approved (by ISQua) hospital standards. Some of this interest was piqued by perceived opportunities in the medical tourism market. Where that was not the case, the accreditation programs have been donor dependent, and perhaps donor driven.

A number of large and experienced organizations are ready, for a price, to work with national bodies in developing CHE and accreditation programs. Often mentioned is JCI from the US, but the UK has at least two experienced organizations, Trent and CHKS, and the Australian Council for Healthcare Standards International (ACHSI) and Accreditation Canada are also in the field. While it is acknowledged that these organizations have a great deal to contribute in assisting the creation of an accreditation program, the influence of their national heritage becomes quickly evident. For example, they often lead with standards on patient rights and privacy. Standards for clinical practice – diagnosis and treatment – are present, but a reader might get the impression that the quality of clinical practice is believed to be well in hand, whereas a US/UK/European hospital needs to be goaded to take patient rights and privacy seriously. This could be correct; however, a developing country might want more emphasis placed on the technical provision of care, without sacrificing emphasis on patient rights.

SECTION III: ACTIVITIES CONDUCTED DURING TDY

The consultant traveled to Ramallah, West Bank, 29 August through 25 September 2009. Meetings were held with hospital directors and officials in the MoH, Medical Association, Nurses Association, schools of medicine, schools of nursing, NGOs, and UNRWA. The initial intention of these meetings was information gathering for the strategic plan. It became evident early in the discussions that the Project's counterparts were ready to explore avenues forward. Commitments were obtained for major policy changes from surprising sources. Among those supporting re-licensing were: Director of CME, MoH; Director of Planning Unit, MoH; Director of Al-Watani Hospital; Director of Licensing and Accreditation, MoH; Director of Nursing Unit, MoH; Chief of Health, UNRWA; Director of Ibn Sina College; Head of the Nursing Association; Secretary General of the Medical Association; Director of the Medical School, An-Najah; Secretary General of the PMC; and the Director of Al-Mukassad Hospital. These open expressions of support bode well for the vision and commitment to better healthcare.

In light of this enthusiasm it was possible to entertain more concrete alternatives with the interviewees. Discussions ranged over what kinds of CHE a facility might offer, how remedial training might be provided to those who failed the PMC's licensing examination, and how future regulations/bylaws/instructions might be framed to reduce concerns and ease the transition to the new policies.

Thanks to the generally positive climate, it was also possible to draft an accreditation policy. The focal person for accreditation (IDP module 6) collaborated with the consultant in drafting the document. Note that this "policy" is a talking paper and does not represent a consensus of stakeholders; some of the discussion/decision points are indicated by suggesting options in text boxes or leaving blanks.

The consultant also reviewed documents prepared by Project staff, relevant Palestinian laws, MoH plans and reports, statistical reports, research findings on the three areas and other documentation relevant to the assignment (see Annex A).

The scope of the consultancy and the recommendations encompass all 33,000 health care providers in the Palestinian health sector: nurses, physicians, radiology technicians, pharmacists, dentists, therapists, midwives, and on through the list. That said, it would be naïve to ignore the disproportionate influence physicians can have on service quality, and, consequently, they receive disproportionate attention. But, the term "continuing health education" is used advisedly to emphasize the inclusiveness of the three professional improvement activities.

It must be noted that any success of the assignment was owed to the planning and arrangements made by Project staff. Upon arrival the consultant was presented with a complete schedule of meetings which had been arranged and confirmed by staff. A large debt of gratitude is owed them.

SECTION IV: FINDINGS, RECOMMENDATIONS, AND NEXT STEPS

A. Summary of Findings

The main, and most gratifying, finding was the readiness of counterparts to move aggressively in all three areas. Where resistance or turf protection had been expected there was support and a willingness to collaborate. The consensus among Project staff who attended these meetings was that the attestations of support and collaboration were genuine. If competition were to break out it might well be for the title of Principal Champion of the Cause. Before turning to recommendations and future steps, the key findings can be summarized in the following points:

Climate for policy reform. As noted repeatedly above: positive. As one further illustration, it might have been expected that the Medical Association (Syndicate), which represents physicians, would resist mandatory re-licensing in that such a change could imperil the livelihoods of the members. On the contrary, the Secretary General and three Board members described efforts already underway within the Syndicate to require 26 hours of annual CHE for GPs as a condition to retaining a license to practice.

Legal framework for policy reform. An initiative to introduce policy changes in facility and professional licensing is underway. The revised polices will have the force of law and should raise the standard for both facilities and professionals; however, further changes will almost certainly be needed to implement the reforms expressed in the IDP.

The Director of Licensing and Accreditation in the MoH is embarking on a revision of relevant licensing bylaws. Note that the MoH provides a license to operate a facility and only ensures that the *capacity* to provide care is present. This license is not a certification of the ultimate quality of services delivered and is not to be confused with accreditation. That noted, there is still room to apply pressure for steadily increasing standards in these basic requirements. The Licensing Department envisions redrafting 27 bylaws by the end of the year. They plan to have separate bylaws for facilities and the professionals in those facilities. For illustration, there will be three new bylaws governing the practice of pharmacy: one for pharmacies, another bylaw for pharmacists and the third bylaw for assistant pharmacists. To date the Licensing Department have redrafted bylaws for two professional areas, dentistry and radiology technician. Licensing Department staff tend to regard this as not a controversial area. However, it would be possible to include provisions in these bylaws that would simplify later policy reform.

Some background on the distinction between laws, bylaws and instructions will help delineate the options available in modifying the legal bases for policy reform.

An official policy may be introduced as a law, a by-law, or an instruction issued by a Ministry. The differences between adoption of a law and a bylaw are small; instructions are relatively simple to introduce by comparison with the other two.

Policy changes require enactment of a law when there is no legal precedent, no extant general provision of law under which clarifications or specific provisions can be fit, or the policy change conflicts with existing law. Using the MoH as the relevant example, the steps are the following:

1. The Minister of Health presents a draft of the proposed law to the Cabinet.
2. The Cabinet may debate the draft at this point. If so, there may be questions sent to the presenting Ministry for answer.
3. The Cabinet refers the draft to the Legal Office of the Prime Minister for comment.

4. After receipt of the Legal Office's comments the Cabinet debates the draft and may send questions or suggestions to the Ministry.
5. If the Cabinet approves the draft, it is sent to the President for approval.
6. The President refers the draft to his Legal Office for comment.
7. The President may approve, reject, or send the draft back down for further development. The President may also ignore the draft, effectively tabling it indefinitely.
8. Approval means the President will issue a decree.
9. This decree must subsequently be ratified by the Legislative Council if and when it is able to resume meeting.

A by-law may be employed when there is a general provision in an existing law and the by-law seeks to clarify or operationalize that general provision. Case in point: the health insurance scheme. The MoH is authorized, under the Public Health Law, to create a universal health insurance program; the MoH could also argue that this provision is sufficiently specific that an instruction can be issued.

1. The process is the same as the first eight steps above.
2. A by-law does not require Legislative Council approval.

An instruction may be issued when the general outlines of the policy are already set in law and the Ministry seeks to operationalize the policy. Cabinet approval is required – steps 1 – 5 above, but an instruction is <u>not</u> sent to the President's office.

In the current context, there is little to be gained in arguing that a policy change is a by-law rather than a law. In the absence of the Legislative Council the process is the same and, moving to the higher standard (law), one point of contention is side-stepped. There is, however, a lot to be gained by classifying a policy change as an instruction.

Regarding the political process, there are a few recent examples to instruct us. Observers feel that the questions raised by the Cabinet regarding the health insurance law have, thus far, appeared free of political animus or concern for personal advantage. The questions sent down to the MoH by the Cabinet challenge the inclusiveness of the process by which the draft was developed and how current insurance schemes – private, UNRWA – will fit into the new program.

There is disagreement on how dispassionate the Cabinet is in debating these matters. Regarding the recent health policies, it seems that personal advantage and party politics have played only a minor role. In other, more contentious areas such as land rights, the debate can become more politicized. In the general case, proponents of a change pursue two avenues: the first is to marshal an impressive show of support that reassures decision-makers that the proposed change is technically sound and politically popular. The second avenue is to avoid embarrassment for the government; as an example, a nationwide doctor or nurse strike would be a problem.

Authority to issue licenses (and perhaps, by extension, impose re-licensing requirements) is divided between the MoH and PMC. According to the Public Health Law, "the Ministry of Health must perform the following . . . Licensing and monitoring medical and auxiliary medical professions." There may be scope for re-licensing under this. There is also specific provision in the Public Health Law to revoke a license: "The ministry has the right to terminate temporarily the authorization given for the performance of medical or auxiliary professions. And it has the right to terminate the authorization permanently. This decision shall be written and justified."

The MoH issues a physician a license to practice *general medicine* upon presentation of documents, including evidence of success on the PMC's exam. The MoH does not issue licenses to practice a specialty; the PMC does, under provisions of their own enabling law. The implication of this division of authority is the following: The PMC could rescind a license to practice a specialty if certain conditions (e.g., CHE) were not met. The PMC could not, however, rescind a license to practice general medicine as that license is issued by the MoH. The MoH, as the issuer of the basic license to practice medicine could – under a liberal interpretation of the Public Health Law – rescind a doctor's basic license to practice medicine, regardless of specialty.

It must be noted that the legal basis for the MoH to impose re-licensing requirements is not definitive and may be susceptible to legal challenge. A clarifying bylaw would provide insurance against such challenges.

Relevant provisions of the Public Health Law regarding the MoH's licensing and monitoring authority over physicians and other medical personnel follow:

Article 2
. . . the Ministry of Health must perform the following . . .
Licensing and monitoring medical and auxiliary medical professions

Article 62
It is not permissible to practice any medical or auxiliary profession before attaining specific conditions from the concerned ministry and association.

Article 63
It is not permissible to practice any medical or auxiliary profession without an authorization.

Article 64
The ministry has the right to terminate temporarily the authorization given for the performance of medical or auxiliary professions. And it has the right to terminate the authorization permanently. This decision shall be written and justified

The enabling law for the PMC contains references to licensing, and potentially, re-licensing. Again, the basis for mandatory re-licensing of specialists rests on a general interpretation of the law, with special reference to the final article cited below. The PMC does have some authority over general practitioners, but concerns itself primarily with the preparation and certification of specialists. Note the following articles concerning the PMC's scope of authority:

Article 4
. . . to set the training description for the preparation of general practitioners during the first year of internship and to describe the specialties in their fields – both within and outside of The West Bank and Gaza – and to review.

Article 5
The PMC is responsible for issuing all specialized certificates for doctors who meet the prescribed conditions and who pass the exams that have been prepared by the specialist scientific committees.

Chapter 5, General Rules, Article 26
It is forbidden for any doctor to declare him or herself a specialist unless s/he has his specialist certificate issued by the PMC.

Provision of Certificate, Article 33

A certificate is licensed for a specialized physician after s/he has met all requirements and passed the specialized exam of the PMC.

The PMC issues certificates and determines validity.

This last article may be the strongest hook on which to hang re-licensing if "validity" is assumed to include period of validity. Again, and despite the enthusiasm for reform noted above, when entering into potentially controversial policy changes, greater clarity is always welcome.

Summarizing the findings in this area:

- An effort is underway that will strengthen, somewhat, the controls on professionals and could raise standards for professionals and facilities.
- There are legal provisions for introducing mandatory re-licensing requirements for GPs and specialists, but they are not unambiguous and might be challenged if exercised.
- As noted earlier, there is an extant provision requiring nurses to complete CHE requirements for annual re-licensing. A quality and compliance system could be placed over this to give it substance.

Antecedents. The main findings in this regard have been presented above; a general restatement is:

Accreditation. The one "accrediting" activity is carried out by the PMC as it certifies facilities as teaching sites. While there is some commonality with facility accreditation as practiced elsewhere, the scope is highly focused. Hospital directors say they have only a vague idea of what accreditation entails and observers believe that only two large NGO hospitals in Jerusalem are positioned to seriously consider accreditation by an international body. There is, however, considerable interest in accreditation in the region and examples of a few private hospitals which have been accredited by international bodies.

CHE. Providers who work in the public sector, major NGOs or UN agencies do receive continuous education in their professional fields. Private providers in a few major hospitals also receive annual refresher courses. Beyond that it is believed that few in the private sector receive much training.

Re-licensing of professionals is non-existent.

B. Recommendations

The recommendations for the three areas are presented separately, but with a common organizational framework. In many instances the recommendation consists of a suggestion that the national leadership in health make a decision on a specific issue. In some of these cases pros and cons of alternative actions are offered, but in others, the decision may be almost arbitrary, the product of a negotiation process in which stakeholders arrive at a modus vivendi.

The general organization of the recommendations draws on the suggestion that it provide a "roadmap" for the health sector. In application the metaphor is helpful when charting a course to CHE, re-licensing and accreditation. The organization of each of the three sections is as follows:

Destination. In the present case there have already been commitments made to destinations bearing these three general titles, but those are about as precise as saying that one intends to vacation at a beach. The destinations are not yet decided upon with any precision and those decisions have obvious importance for the costs, schedules, and value to be derived.

Value. Regarding the last – value to be derived – investments of this magnitude deserve examination of the benefits likely to be obtained.

Incentives. Policy reform is inherently political. That is not to deny that technical issues figure large in policy discussions, but those technical issues are often presented selectively to bolster a position that has been taken to advance the interests of the person or group making the argument. In health care debates, patient welfare is usually invoked by all parties in support of their competing positions. As in all things involving humans, behavior is governed by the rewards and punishments for pursuing one course over another. Health professionals act the way they do now because the incentive system, for good or ill, has shaped that behavior. If different behaviors are wanted – and reform implies that they are – the incentives will have to be changed.

The first section for each of the three areas will examine alternative end points to the process, the benefits in health outcomes and efficiencies that might be realized, and the incentives that can be enlisted in changing practices and systems.

External assistance. Pursuing the roadmap/trip analogy, the next consideration is mode of conveyance. We can do it ourselves – everybody into the family car – or outsource much of the work. If the decision is made to bring in external assistance, the class and cost of service become important. Organizations working in these areas vary in the depth of their experience, their prestige, and their costs. Some non-US hospitals report spending $100,000 to $200,000 for JCI accreditation, exclusive of additional investments they had to make to pass. In 2006 there were 78 hospitals in The West Bank and Gaza, 24 of them operated by the MoH. The direct expense of JCI accreditation to the society could range between $7.8 and $15.6 million; to those figures several million more would need to be added to redress infrastructure and equipment deficiencies. Such costs cannot be borne by The Palestinian Authority, or, alternatively, international accreditation would have to be limited to a select few facilities.

The second section for each of the three areas examines the alternative technical assistance options, the experience of those organizations, and their costs.

Obstacles. No trip is free of them, whether they are resource constraints or calamities that befall the traveler. Some of these obstacles are known and can be planned for. Others cannot be planned, but provisions can be made against their occurrence. A homely example is

the spare tire carried in the trunk; no one knows when a puncture may occur – it probably won't on this trip – but the cost of making provision against that occurrence is far less than being caught unprepared. So it is with major policy reform. If we can anticipate all that might go wrong and have resources on hand to resolve problems we will be in much better shape should they arise. A singular problem has to be addressed in this regard: donors are unaccustomed to setting resources aside "just in case."

The third section discusses the obstacles, such as resistance, the capacity constraints, and, importantly, what those capacity constraints are for the long as well as the short term. In the short term the resources of the Project can overcome many resource constraints, but the long term is another matter.

<u>Routing</u> is an obvious planning activity. There are many decision points and the fourth section will list those with a brief review of the merits of alternative paths. Combined with "Schedule," this section most closely represents a narrative roadmap.

<u>Schedule</u>. The first question on schedule is when to depart. That is the easiest to answer: immediately. The clock is ticking on the Project and a nucleus of influential supporters has been identified. Conditions are unlikely to get better and they could easily get much worse. Added to that, the lead times for many of the activities are long. To start immediately does not mean to race headlong toward the goal, the pace at which changes are introduced must be measured and not provoke concern among stakeholders.

The proposed schedule is inexact, but does separate those activities and decisions that must be conducted in sequence, those that can or should be conducted concurrently, and those activities and decisions that are, for various reasons, deferrable.

<u>Costs</u>. Since the costs are associated with decisions regarding type and extent of external assistance, range of activities to be included, breadth of the coverage, and so on, estimated costs will be offered in the <u>few</u> areas where there is a precedent on which to base them. This will not be a separate section of the report.

<u>Decisions</u>. It should be evident from the foregoing that, as with any trip, there are numerous decision points. There are, of course, the many operational details that have to be worked out in setting up a CHE system. As two illustrations: How are credits counted? If contact hours are used, how will internet learning be handled? Here the focus will be on policy level decisions which have far-reaching impact on system design, its acceptance by stakeholders, its effect on service quality and its long term viability. Where possible the decisions will be stated in discrete terms and *italicized* to signal them. Breaking decisions into components does not make the decision making simpler, but it may confer order on the process. The most often cited alternatives will be briefly stated.

<u>Not included</u>. This is not the first report to be produced by the Project on these topics. Earlier, excellent reports were developed; it is assumed that the readers of this have read or have at their disposal the two papers prepared by Mary Segall in January 2009, "Guidelines for accreditation of continuing professional development for health professionals," and "Accessing (sic) accreditation readiness: A tool for policy makers and program implementers" and "CHE: A framework for the Palestinian Health Sector" by Nadira Sansour. This report will not duplicate the information found in those.

B1. Continuing Health Education

Destination

As signaled in the preceding section, it is necessary to start by determining what variety of CHE is the goal. Short courses spring to mind when the term, CHE, is mentioned, but there are other activities that qualify for credit toward re-licensing requirements. There are conferences, online learning, publishing, research, participation in grand rounds, reading, discussions, and on and on. Perhaps as a concession to healthcare provider resistance, CHE accrediting bodies have cast a broad net and virtually any learning activity that has a bearing on the professional responsibilities and performance of the provider could be considered.

Quality control and deeming. The problem is that if all these diverse activities are to count toward licensure requirements, someone or some organization has to deem them appropriate professional learning experiences. This has given rise to the CME/CHE accreditation authority, or, more accurately, authorit***ies*** as there is often a cascade of relegated responsibility from an umbrella organization (e.g. the American Academy of Continuing Medical Education and the Accreditation Council for Continuing Medical Education – both umbrella or capstone organizations for physician CME) down to the next level of accrediting organizations which may focus on a specialty. For example, the Society for Academic Continuing Medical Education, another umbrella organization, recognizes credits from CHE/CME offered by training providers that are accredited by any of the following: American Academy of Family Physicians (AAFP),Association of American Medical Colleges (AAMC),American Board of Internal Medicine (ABIM),Accreditation Council for Continuing Medical Education (ACCME),Accreditation Council for Graduate Medical Education Accreditation (ACGME),American College of Physicians/American Society of Internal Medicine (ACP/ASIM),American Medical Association (AMA),Liaison Committee on Medical Education (LCME), and Office of Postsecondary Education (USDE). Just one of these, the ACCME, accredits state boards (50 of them) in the US which – one more tier – accredit training given within their states. Not surprisingly, this complex system of accreditors yields a large number of approved training providers, over 16,000 in the US alone.

This leads to the first decision point: *How will The Palestinian health sector ensure consistent quality of CHE?* The answer will almost certainly involve empowering an organization to set standards and apply those standards to accredit training organizations as well as examine the quality of individual training programs. The factors in the decision are:

- If practitioners will be expected to attend 30 hours of training per year (a number slightly higher that the median for the US – 25 hours – on the justification that many Palestinian healthcare workers need to catch up, a lot of training will be needed. There are around 33,000 healthcare providers in The Palestinian health sector who would absorb approximately 125,000 training person-days. If 25 people attend each CHE course, 5,000 one day courses will be required each year. These numbers become less dramatic when we allow for internet-based learning from already accredited sources, or longer training programs, but it will still be a daunting task.
- Quality must be kept high from the start. If not, CHE devolves into a derided exercise in futility, and if mandatory, an annoying exercise in futility. That means the body that accredits CHE will have to examine what is being offered and be willing to withhold training certification from organizations that do not measure up. There are clear implications for staff, resources, independence and perceived impartiality.

- The process for receiving accreditation to offer CHE approved training cannot be onerous, or it will be impossible to meet the heavy training demands described.
- Cost. It is difficult to find an applicable guide to costs. The AACME and ACCME appear to charge an organization seeking accreditation as a CME training site around $15,000 for one-year accreditation; subsequent annual re-accreditation costs half this amount. If these are deflated for Palestinian costs to as low as $2,000, the number of organizations that might seek accreditation as CHE providers will still be limited and they will have to pass those costs on to course attendees, who may already be chafing at the new requirement to spend time and money to keep their licenses.

The most often cited options as CHE accrediting organizations are:

- The Palestinian Medical Council (PMC) currently accredits hospital-based teaching programs. These are not short courses, as CH/ME often is, and the current focus of the PMC is on ability to provide clinical training; however, the principles of accrediting pre-service training and CHE are similar in many regards. The PMC also enjoys some infrastructure that could be further expanded.
- The Ministry of Health (MoH) as designated guarantor of healthcare quality is always a candidate for this kind of regulatory role.
- A new, specialized, organization might be created. Several organizations might be created if the decision were made to establish a separate entity for each health profession. This is the most commonly found option, although it would be the most expensive in the short run and would need to quickly introduce a system of fees for accreditation surveys and membership that would cover the costs of the organization. While cost recovery will also be a goal for the first two mentioned, the PMC and MoH have other sources of income and resources that would help during the startup period.
- The Medical Syndicate has expressed interest in coordinating CHE, and given recent forceful activities on the part of the Syndicate to require CME of GPs, they deserve to be taken seriously. Due to an in-built conflict of interest, it seems unlikely that the professional syndicates will be allowed the primary position in CHE accreditation; however, they need to be at the table. They will almost certainly be on the steering committees, advisory boards, and other policy making bodies, and, if they follow the pattern in other countries will also offer training courses for members.

The question for the Project and counterparts is: *Where the investment in this accreditation body will be made? PMC, MoH, Syndicate, or new entity.* There is no technically right answer to that question, but rather, the answer must balance factors of perceived legitimacy, cost-effectiveness, and sustainability.

Course offerings. As above, the offerings available to healthcare professionals in other societies represent a vast buffet of courses, conferences, etc. In common with other upper-level educational programs, there are often required courses and elective courses. The titles of the required courses in the US are instructive as they follow the shifting fashions in healthcare. Some examples: Pain management and end of life care are now required by several US states; Connecticut wants sexual assault and domestic violence in the required training;

New Jersey wants cultural competence; Iowa demands child abuse training; and so on. What knowledgeable people in the sector have proposed are the following:

- Required courses should be those the practitioner would not attend if not obliged to do so. Example topics include infection control and life support, the fear being that many practitioners do not understand how weak their skills might be in those areas.
- Required courses should be in the specialty to ensure continued competence to practice the specialty. Beyond that, the healthcare professional could sample widely across the healthcare spectrum.
- Required courses should be on emerging health problems (H1N1 and avian influenza are two recent examples).
- Required courses should be in basic, primary care, as that is where the biggest gains in public welfare can be made.
- There should be no required courses.

Again, there is no clear and obvious winner among these options. Citing the US – only because CME is such a major industry – states can be found that follow each of these. *Will there be required courses, and if so, what will they be?*

One division of training objective often mentioned is remedial training vs. training to remain professionally current. As a tenet of academic marketing, it is rarely a good idea to label a course "remedial" if attendance is voluntary. There is, however, a persuasive case to be made that many health professionals in are not equipped to provide safe care to patients. The longer courses required to bring foreign medical graduates – for example – up to national standards should be left outside the CM/HE framework. It is tempting to use CHE requirements as one avenue to redress the pre-service training deficiencies of many of these men and women, but to do so undermine the image of CH/ME training as the avenue to keep abreast of a rapidly moving field. I recommend relying on and strengthening the qualifying exams. If there is a market to provide refresher or remedial training programs to improve the pass rate, it is likely that the leading schools of medicine will respond to the opportunity.

Value. In light of the size of the investment required in CHE, a question of some primacy is: Does CHE deliver better health care and outcomes? Given the worldwide epidemic of medical training, many obviously assume the answer is an unambiguous yes. In fact, the research literature, while offering mild encouragement, should give us pause. Here's a quote from a review of research on the effect CHE has had on long-term care: ". . . there is minimal evidence that knowledge gained from training programs is sustained in the long term."[1] That report falls at the more negative end of the spectrum; the more common finding was consistent with the following conclusion, based on a review of 136 studies: "The preponderance of evidence demonstrated improvement in physician application of knowledge with CME."[2]

Regarding health outcomes, an early review, 1992, reported, "The majority of the 43 studies of physician performance showed positive results in some important measures of resource utilization, counseling strategies, and preventive medicine. Of the 18 studies of health care

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[1] Sandra Aylward, Paul Stolee, Nancy Keat, and Van Johncox. "Effectiveness of Continuing Education in Long-Term Care: A Literature Review." *The Gerontologist* 43:259-271 (2003).
[2] Kevin M. O'Neil, and Doreen J. Addrizzo-Harris. "Continuing Medical Education Effect on Physician Knowledge Application and Psychomotor Skills." *Chest* 135: 37S-41S (March 2009).

outcomes, eight demonstrated positive changes in patients' health care outcomes."[3] To reiterate the point: eight of eighteen studies documented improved health outcomes. The lesson from this is that the evidence supports investing in CHE, but positive outcomes should not be taken for granted.

Training methodology is a related area of interest. The accrediting bodies all urge reliance on only the best – by evidentiary proof – teaching methods. Again, research provides a cautious yes to newer training methodologies. To cite one of many studies, a controlled experimental comparison of internet-based with in-class-training concluded, "Appropriately designed, evidence-based online CME can produce objectively measured changes in behavior as well as sustained gains in knowledge that are comparable or superior to those realized from effective live activities."[4]

The purpose of this brief excursion into the research literature is to underscore two points: 1) CHE, live or online, can improve provider performance and health outcomes, but, 2) that result is not guaranteed. This underscores an earlier point: the importance of the accrediting body to ensure consistency, quality, and a focus on competence.

INCENTIVES

There are favoring incentives such as professional pride, a marketing advantage (private sector), and respect and status among patients and colleagues. There are also restraining disincentives: time, additional burden, or loss of income (private sector). The social psychologist, Kurt Lewin, made two observations about these opposing incentives. The first and obvious one: any increase in positive incentives or decrease in negative disincentives will yield movement in the desired direction. Lewin's second observation is less obvious: An increase in positive incentives without a decrease in disincentives may lead to desired movement but there will be greater pressure at the interface. If we accept that most people do not enjoy an increase in personal discomfort, the implicit recommendation is that any effort to change incentives should give equal attention to reducing the restraining forces.

The strongest incentive at work in this area is risk of loss of license. This is the driving force in the US and, with the advent of re-licensing requirements in the UK, will be the same there. It seems agreed that attendance at CHE may benefit from this incentive within a few years, but the consensus has been that mandatory re-licensing has to be phased in. CHE attendance will, initially, need to rely on other sources of appeal. Here it is helpful to discuss the public, NGO and private-for-profit sectors separately.

Public sector. This sector is the least challenging. Ask a public sector provider if he or she prefers spending time with sick people or getting a few days off in a comfortable training setting, and the answer is predictable. The answer changes some when we hope the provider will take initiative to enroll in online courses, read journals, or undertake other independent learning activities that free the MoH and Project of the cost and effort of mounting courses. The incentive structure does need to be addressed to encourage independent learning in the public sector. From easy to implement to more difficult, the positive incentives include:

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[3] David A. Davis, Mary Ann Thomson, Andrew D. Oxman, R. Brian Haynes. "Evidence for the Effectiveness of CME: A Review of 50 Randomized Controlled Trials." *JAMA* 268 (9):1111-1117 (1992).

[4] Michael Fordis, Jason E. King, Christie M. Ballantyne, Peter H. Jones, Katharine H. Schneider, Stephen J. Spann, Stephen B. Greenberg, Anthony J. Greisinger. "Comparison of the Instructional Efficacy of Internet-Based CME With Live Interactive CME Workshops: A Randomized Controlled Trial." *JAMA* 294:1043-1051 (2005).

Formal recognition of independent study; these include training recorded in the attendee's personnel file, certificate issued, and statements of appreciation in meetings.

Public recognition. These could be a framed certificate prominently displayed, citation in the press, or the opportunity to lecture/make a presentation on the topic to peers.

Professional reward; for example, assignment to more interesting cases.

Personal reward. These are the hardest to implement but may have the most influence on behavior. Independent learning improves the likelihood of promotion or pay increase, or added leave, or assignment to better facilities.

The disincentives for independent learning by public sector providers that can be reduced are primarily logistical. As examples:

- Access limitations. These disincentives can be reduced through improved access to learning resources such as computers and "enduring" materials either at the workplace or that can be taken home.
- Computer-phobia still cannot be counted out. Some personal hand-holding in the learning lab may help as the learner makes his or her first forays into e-learning.
- Time is always a constraint. This disincentive is reduced if there is the opportunity to dedicate some portion of working hours to independent learning.

Where a change in the civil service law is not required, these are not difficult changes to make, and any combination of them should increase independent learning.

NGOs. For the individual healthcare workers within the NGOs, the incentive system for either guided or independent learning looks much like it does to the public sector employee. For the NGO management, however, the perspective is different. They must allocate scarce resources to make this work and that is key. Independent learning is more efficient for the NGO and, if management sees the alternative as paying for formal courses, they may turn to the incentives just listed to encourage staff to avail themselves of independent learning opportunities.

Positive incentives that may encourage NGO management to allocate resources to staff CHE training include:

- Referrals from the health insurance program,
- Rumblings from the MoH that NGO service quality is a "concern;" NGOs the world over fear capricious and prejudicial regulation from the government,
- Competition for paying patients,
- Institutional pride; the perception that the public sector is investing in training may be a spur to NGOs to protect an image of superior service quality.

Negative disincentives that could be reduced might include:

- Cost – inclusion of NGO providers in Project subsidized training would help NGO managers accept the (lower) expense,
- Lost time of staff – schedule training for non-working hours (that, of course, removes one of the incentives for individual staff to attend).

Private for-profit. The large number of after-hours dual-employment health personnel is often noted as the mechanism by which any knowledge improvements among MoH staff provide a corresponding improvement in the private sector. I have not seen figures on the proportion of care provided by true private sector providers; patient reports (as in the DHS) may be unreliable. The 23 private hospitals rely, presumably, on staff who are not moon-

lighting from the MoH. Whatever the case, the quality of private sector service has to be taken seriously.

The incentives ascribed to private providers are usually economic. Will training improve revenue (market advantage) or reduce it (time lost from practice)? Either positive or negative, the incentive structure is easy to understand, if not to manipulate. Perceptions of improved market position are fostered through carefully worded titles on courses, use of recognized experts as trainers, visually impressive framed certificates, press announcements of the event and attendees, and course offerings that appeal to the ultimate consumer. Loss of revenue can be minimized by careful scheduling. The problem with scheduling is that the hours that the private provider can get away from his or her practice may not be the hours that the public sector and NGO providers find congenial. As a consequence, separate training events may be required for the private providers.

Demand among private professionals is affected by price. How much will a doctor or pharmacist voluntarily pay for a one day course? One-hundred NIS has been suggested, but no one knows the answer. What can be known, however, is the cost of various training options: in-class, clinical without patients, clinical skills with patients, laboratory examination skills, radiology, and so on. This cost information is important to know as it will set the target price for the future when donor subsidies are reduced or withdrawn. For the present it provides a logical basis for negotiating subsidies with donors.

A final word on the topic of motivating course attendance from the private sector. The decision to participate may hinge on small factors. If it is necessary to train on Friday to get around the lost income problem, new obstacles are encountered (sacrifice of family time). Here are examples of "counter" incentives that have worked in practice: Invite family members of the attendees to the "graduation" dinner so that the spouse and children can spend more time with the trainee; provide a very good meal; ask the same family members to attend the awarding of certificates so they can applaud as he or she walks up to the stage and accepts a certificate and shakes the hands of dignitaries; ask a famous artist or cartoonist to provide the illustrations for the training materials, making them collectors' items which are distributed only to attendees in the course. Many small positive incentives may be able to offset a few large <u>dis</u>incentives.

External Assistance

Three areas can benefit from external assistance: setting up the accrediting body, designing the training program, and offering the courses.

<u>Setting up accreditation</u>. For all its ills, the US health system has the most experience in this area. There are two umbrella organizations. ACCME states that it does not work outside the US, but I had personal contact with some of their officers in 2004 and there was strong interest at that time in undertaking international work. AACME does have an international arm with a presence in many countries and modestly states, "By global appointment of 96 Ministries of Public Health and medical authorities, the AACME is authorized as a preeminent body for accrediting Continuing Medical Education activities and programs (including enduring materials), by setting and maintaining CME accreditation standards." Unfortunately the Eastern Mediterranean office of AACME is in Washington and Palestinian Authority is one of a handful of countries "Pending – under review" along with Iraq and Jordan. However, AACME seems eager for the business although it is unclear how much support could be expected in setting up the CME accreditation program. The fees for one year accreditation might be around $15,000, although provision is made to waive certain fees for special cases such as the West bank and Gaza. Note that this figure is for accreditation, not for technical

support. While The Palestinian health sector might not need or want the services of these organizations, it may be worth investigating to determine what services AACME and ACCME are prepared to offer, and at what price. Given the workload at the Project, outsourcing some activities may be appealing.

Decision point on assistance for CHE accreditation. There are two decisions to be made:

> *Does the Palestinian health sector want external accreditation of its CHE program?* This would be of value if health providers wished to receive credit for courses taken here against re-licensing requirements elsewhere. This might be of value for a handful of practitioners who are board certified and licensed in the West. Another positive would be the prestige that attaches to an internationally accredited CM/HE program. A clear negative is cost.
>
> *How much external assistance does The Palestinian health sector want in setting up the CHE program?* There are nuts and bolts issues of setting up the data base, establishing standards for accredited courses, training staff in the accrediting agency, and so on. None of this is especially difficult, but it can be time consuming. If the technical assistants know what they are doing, the process might be accelerated.

Designing the training program. First, what needs to be taught? The arguments seem to turn on degrees of precision. I have been vocal about the futility of arriving at – via a "robust" needs assessment – a definitive statement of training needs. These assessments are time consuming and can be misleading, especially if they rely on provider self-assessments of training needs. Two further cautions:

> There is always the tendency of sending to market that which we produce; client needs are an after-thought. If you ask the head of primary care what needs to be trained, he will likely tell you the greatest need is for more on primary care. If you ask the head of a family medicine program what needs to be trained, you can again predict the answer. These are not self-serving answers; they simply reflect the daily frame of reference within which these people operate.
>
> If this activity is to be outsourced, considerable caution should be exercised in selection of the assessment group and the terms of the contract. Since this is a precedent activity – little training starts without it – delays and non-performance are fatal. Recall the contract with Bir Zeit University on health legislation.

Given these pitfalls, how best to proceed? Dispassionate observers of healthcare provision may provide at least as accurate an assessment – and certainly a faster and cheaper one – than can be obtained through a more elaborate process of canvassing facility directors and staff. Dr. Hammouz', Director of Continuing Education at the MOH, frustration at the limitations on the results he obtained through such a process provides evidence. At the risk of chauvinism, foreign clinicians who have been working with national providers may also be able to offer useful insights on skill and knowledge needs. A conscious decision should be made and implemented: *How will the training needs be determined?* Recall the earlier decision on kinds of training: specialist, general, primary care, etc.

Offering the courses. A final question is how much of the training should be outsourced. Granted, the MoH, UNRWA, and large NGOs will expand their own offerings, and perhaps market them to others. Beyond that, the major teaching hospitals could be canvassed for proposals, as could the various syndicates. An early policy decision on this point would help potential training providers in their planning. A range of options:

All training will be managed through a handful of official providers such as the MoH, PMC, UNRWA. Any third party wishing to offer a for-credit course would approach one of these and offer it under their aegis. The clear advantage is that it simplifies quality control. It also makes it easier for the Project or other donor to subsidize courses. A possible disadvantage is that it may create a bottleneck.

Third party training organizations will offer training only at the invitation of the national accreditation authority. To be clear via an illustration: The PMC or MoH could decide a course in gastroenterology was needed and would ask Najah University to propose a course that responds to certain defined learning objectives. The disadvantage is that this shifts more of the burden onto the national accreditor to identify needs and seek out training opportunities. Control over training is improved via this mechanism, but it is questionable whether this additional control adds to quality or relevance of the courses.

Training organizations may apply for accreditation. Once accreditation was received, they would then clear all courses with the accrediting authority. Quality control is enhanced and donors may selectively subsidize training in areas of perceived interest. On the down side, there is still a potential bottleneck.

Trainers or training organizations may, without accreditation, present course proposals to the accrediting body for approval (or rejection). This eliminates one step, accrediting training organizations, but shifts the burden onto examination of each proposed course for rigor, relevance, use of best methodologies, etc.

Course approval would be post hoc. Providers would bring evidence to the accrediting body of training completed. This is not as bad as it may first seem. The course would have to be certified only once, when the first attendee presented documents. The disadvantages of placing responsibility for certification on attendees are: the attendees may botch the job, misplacing documents, or applying late; the accrediting agency loses the opportunity to have input into the training before it is conducted. Note that some kind of post hoc certification window will have to be open to handle the courses taken overseas, e-learning, credit for research and publication, and all the other professional development activities that are not traditional courses.

Decision point: *Which of the above, or what combination, will be used for CHE course accreditation/certification – ensuring that a broad array of courses are available to providers?* The practical implication of this question is *how many training providers are wanted?*

Obstacles

Three groups of obstacles are relevant: resistance, capacity constraints, and sustainability.

Resistance. Some of the resistance issues were raised in the discussion of disincentives above, so we can move quickly here. The earlier discussion focused on resistance arising from rational concerns and tangible problems: lack of time, cost, loss of income, etc. Recall Lewin's advice to reduce disincentives as a means to minimize tension and heat. Here we will take a quick look at the less tangible factors that contribute to resistance.

Not everyone resists change out of apprehension of the unknown, but it is safe to say that some people do and for them, if for no one else, proponents will have to take seriously the resistance that arises from a fear of change or an unwillingness to embrace it.

The simplest remedy is to reduce fear of the unknown by being concrete, clear and consistent in developing expectations about the CHE program. Dissemination workshops are good if they can provide specific information about what is planned. Study tours serve a dual function of educating and co-opting. Participation in the planning process – if managed to

prevent disruptive elements from subverting the process – buys support and often leads to an improved plan. The Project may wish to invest in all of these.

A second remedy is to promote change for its own value. Health workers – and physicians above all – consider themselves members of the scientific community. This can be developed into support for a national health profession that prides itself on competence and professional progress. These values can be conveyed in titles of workshops, position papers, press releases, etc. It does not hurt to go first class in training venue, quality of materials, expertise of presenters, manageable class sizes and attention to participants. Training is a bad place to scrimp.

Pacing. Go too slow and momentum will be lost. Go too fast and otherwise supportive stakeholders may become uneasy. My experience suggests that the tendency is to move too slowly out of excess caution, inertia, and the long planning and lead times required. Advice: Move as quickly as contracting vehicles will allow. It will still probably be too slow; the danger of moving too fast is small.

Phasing. Health professionals are not naive people. They will recognize that a formal system of certifying courses, assigning them "credits," and recording participation are all a prelude to mandatory re-licensing. One response to this is to address head-on the largest fear: loss of license to practice and earn a living. Here providers must be convinced that the risk of losing their license is low to non-existent. It will be important that they are assured of extensive opportunities to meet the re-licensing standards and that attention will be given to scheduling to facilitate participation. And that they can afford to take these courses which, for at least the life of the Project, will be subsidized and only nominal fees will be charged.

Prepare. Those stakeholders nervous about the process will be alert for early signs of trouble, evidence of poor planning, and failure to deliver on promises. Since they will apprehend that mandatory re-licensing is imminent, their resistance will stiffen if they perceive that the support structure is not coming into place.

<u>Capacity constraints</u>. There are two of immediate relevance:

- Shortage of courses.
- Shortage of training organizations.

Shortage of courses. It would be exhausting for the Project to organize most of the courses. It may be necessary, however, for the Project to organize many of the initial ones. This ensures that, a) the course happens, b) the Project's standards are met, and c) through judicious selection of co-trainers the methodology is disseminated. In practical terms, the Project should move aggressively to conduct a series of courses with broad appeal and act to develop the capacity of training organizations.

Shortage of training organizations. Bear in mind that the familiar frame of reference of the major training organizations (teaching hospitals) is the residency. Relatively little about a residency program translates to a CHE course, other than a few learning objectives and, one hopes, some resource persons. The <u>well-done</u> short course may be new to them, despite the proliferation of such courses. There are various ways to develop internal capacity; one is suggested above: co-train with key clinical faculty from the teaching hospitals.

<u>Sustainability</u>. Much of the foregoing is relevant to the long-term viability of the CHE program. The following four activities will further improve the likelihood of a sustained CHE program:

1. An immediate start. The more the Project can support over its remaining life, the less is left for the national program to support when external resources are curtailed.
2. A heavy investment in capacity development. This includes both development of personnel and systems (certification of courses, recording of attendance, tracking of progress toward re-licensing requirements, etc.).
3. Set a high standard. This gives CME a good name and sets a standard that, in a competitive market, will be difficult to abandon.
4. Gradually decrease the subsidy on the courses. A nominal fee at the start, the proceeds used to cover expenses donor funds cannot pay (e.g., the meal for family members of trainees). It is unlikely that the Project will need to get to full cost recovery; history suggests that donor support is usually available for training.

ROUTING AND SCHEDULE

Events in the schedule/route fall into three categories: some activities have to be sequential, some may be conducted concurrently, and some can be deferred past their "logical" point without causing harm. The reason why deferring a decision may even be desirable is that some decisions and activities may need to mature for a while. Fatigue sets in when normally cautious officials and managers are asked to make several major decisions in a short period of time and that can lead to timidity. The successful public sector manager is often more comfortable with incremental changes. Their approach seems to be: "Let's try this; see what happens; and if works out, we'll move on to the next issue." This approach to policy change should not be faulted nor rushed.

We start with the following two groups of concurrent activities, 1 and 2. Within each, the activities are, for the most part, sequential.

Setting the structure

1. Define the end point:

a) Decide: *What organization will provide CHE accreditation of training organizations, courses and other professional learning activities?*

b) Decide: *Will this organization receive external assistance in setting up the program? If so, from where?* Study tours may be indicated at this point.

c) Decide: *Will the organization seek international recognition? If so, from where?*

d) Decide: *Which group of courses, if any, will be required?* (this is deferrable, as the deadline for this decision occurs when mandatory re-licensing takes effect).

f) Decide: *What will be the general provisions of a certifiable training course (level of expertise of trainers, required demonstrations of mastery/competency, educational methodologies, etc.)?*

g) Begin development of the CHE database in the selected accrediting organization (buy equipment, install and test software, select, hire and train data entry person, amass information on current providers – names, locations, qualifications, etc.).

2. Define training needs:

a) Decide: *Select an approach to determining training needs. If it is to be outsourced, who will conduct it?*

b) Conduct the training needs assessment.

c) Develop a comprehensive training plan with the MoH and other consumers of trained healthcare workers.

Tangible evidence of progress.
Once the preceding are underway (not necessarily completed), the following three sequential activities can begin:

3. Identify, provisionally, competent training organizations and their areas of relative competence.

a) Decide: *What requirements will be imposed on accredited training institutions?* Will they need to have reference materials? If they offer clinical skills training will they have to show evidence of sufficient caseload? How will they insure their instructors use effective adult learning methods?

4. Develop course proposals with each in their areas of expertise.

5. Launch two rounds of training these pilot courses (two rounds are usually necessary to refine the materials, methodology, timing, etc.).

6. Evaluate the experience and make concrete recommendations to the accrediting authority on the parameters of certifiable CHE activities.

Incentives.
While everyone will be conscious of the incentives from the outset, a concerted effort to address the incentive structure will need to be made during the first year, especially as some changes will take time to implement.

7. Either in small groups or with individual key stakeholders, discuss the factors that encourage and discourage professional development. Placing some structure on these discussions would be useful and would signal that the activity represents more than idle curiosity. The twin objectives of these meetings are to elicit information and generate support.

8. From these discussions there will certainly come recommendations to provide tangible rewards for those who diligently improve their professional skills and knowledge. Inevitably, some of these recommendations will require changes to the civil service code. *Decide if these types of incentives are worth pursuing.*

a) If the decision is yes, draft by-laws or laws that would implement these incentive schemes. In some countries the easiest path has been an annual salary supplement for accruing X professional development credits. This leaves the salary scale intact and keeps the carrot always in front of the professional.

9. Conduct a systematic review of all activities to ensure that attention is given to reducing disincentives and maximizing incentives.

10. Act on the results of that review.

Training and capacity development.
There are three large concurrent activities here.

11. With the results from step 6 (recommendations on best CHE practices), completion of the training plan, and adoption of guidelines by the accrediting authority, launch a large and well-funded training program.

12. Co-train with national organizations, selectively bringing in external assistance as warranted.

13. Assist national training providers in developing internal capacity. Some example activities might include the following:

a) Materials development.

b) Costing of training.

c) Development of resource centers (computer/learning labs, libraries).

d) Staff training in new educational methodologies.

e) Creation of client databases for more effective marketing of courses.

The following can move concurrently with the preceding three:

14. Assist the national training providers in their applications for accredited status with the national accrediting authority.

B2. Accreditation

As some of the general issues have been discussed under CHE, this section on accreditation will be shorter.

DESTINATION

End point. The likely alternative endpoints would appear to require decisions on the following:

Decide: *Which facilities will be covered?*

Hospitals or more?

MoH or more?

Decide: *Will accreditation be required or voluntary?*

If voluntary, what actionable incentive is there to seek accreditation?

Decide: *Who will provide accreditation?*

National body, and if so, which?

International body, and again, if so, which?

Decide: *If only a few facilities can achieve accredited status (likely), will there be intermediate steps for the others?*

Examining each of these decisions in turn:

Which facilities? There seems to be an assumption that first attention will be given to hospitals. When asked about primary care facilities there is quick acknowledgement that that would be a good idea too, but one does not get the impression that there is strong commitment to going beyond hospitals, at least within the lifetime of the Project. This should not be a foregone decision. In Egypt first attention was given to PHC facilities. Primary care facilities are less complex and easier to survey (stating the obvious), but their inclusion does add a layer of complexity. To illustrate: A primary care accreditation survey is easier; in Cambodia we could survey a health center in 12 person-days whereas a small hospital required 24 – 30 person-days of effort. But the health centers required an entirely different standard and that took time to develop; we couldn't just cut things out of the hospital standard. It appears that many hospital accreditation standards are available, but comparatively few health center standards are.

The decision on the scope of the program will be strongly influenced by pragmatic constraints regarding how much can be done. Standards development takes time and resources, ironically perhaps more so for primary care facilities because there are fewer models. Surveying takes time. Coaching takes time (my experience has been that health centers are often even less prepared for accreditation than hospitals). And some investment is probably needed to bring these facilities up to standard. All that noted, it seems likely that accredita-

tion of PHC facilities will be deferred. If so, perhaps a commitment can be obtained on a timetable that specifies when they will be brought into the system.

Which sector(s)? We have heard more than once that accreditation should start with the MoH and, at an undefined date, extend to a pilot NGO or private hospital. This also should not be treated as an obvious decision. If the insurance system will use accreditation as a criterion for referral, there is an incentive for non-public sector facilities to get on board. If accreditation is voluntary, no decision needs to be made on sectors unless Project or other external resources are to be made available to any facility under-going accreditation.

Voluntary or mandatory? The common practice is voluntary, but in reality the disincentives to lack of accreditation are so severe (loss of 80 percent or more of patients in a US hospital) that no facility can survive without it. A mixed system – mandatory for public facilities and voluntary for others – might also be argued.

Who accredits? The options are limited. While, in theory, international accreditation is feasible, in practice it is cumbersome and expensive. JCI posts fees of ~$40,000 plus travel and per diem on their website but hospitals report spending $100,000 to $200,000 for initial accreditation from JCI. Before dismissing the possibility of international accreditation, there are alternatives that should be checked:

- The Trent Accreditation Scheme, or Trent, which is based in the UK with offices in Hong Kong, the Philippines and Malta, was actually the first to enter into international work with accreditation of a hospital in Hong Kong.
- The Australian Council for Healthcare Standards International, or ACHSI, is based in Australia and boasts of some international work, primarily in the Far East.
- CHKS is another UK based accrediting body that has worked in India, South Africa, and is now engaged with new private hospitals, health centers and nursing homes in Egypt. Apparently the facilities seek to tap the medical tourism market.
- Accreditation Canada – formerly the Canadian Council on Health Services Accreditation or CCHSA – has also done some international work and has Arabic speakers on the staff.

JCI enjoys name recognition, but investigation of the capabilities of the others might turn up a better option.

Even if some hospitals seek international accreditation, the vast majority will not. A national accrediting authority will be required and that leads to the question, *where will it reside?* The following are candidates:

- The quick response is the MoH because the basic operating license is already provided by them. One argument might be that economies could be achieved by rolling information from the licensing process into accreditation. On the other side it should be observed that the organizational skills and perspective required for accreditation are different from those for basic licensing.
- The PMC does look at some of these issues when it accredits teaching programs; however, it may have a lot on its plate with expanded CHE . . . but it cannot be counted out.
- A new entity might be formed – this is actually the most common approach – but the learning curve would be long and steep.
- The National Health Insurance program is still being transformed but it might enjoy leverage other organizations lack. By differentiating between accredited and non-accredited

facilities in payment rates or willingness to pay at all, the Insurance program could exert a powerful effect on some non-governmental facilities to seek accreditation.

All or nothing? Dr. Namari of Makassed Hospital opines that only his hospital is even close to qualifying for accreditation. He may be right. If so, can there be a succession of achievable steps for the others? This step-wise approach to full accreditation was followed in Cambodia and it was psychologically useful for staff to see their efforts rewarded every year as they progressed another increment up the scale. There could be two or three intermediate steps, all with suitable rewards and commendations at each level so that everyone can have realistic goals and gain some sense of success. Note that this progressive accreditation scheme greatly complicates the standard. The standard for each level may bear little in common with the other levels. To illustrate, in Cambodia the first level "accreditation" surveyed only inputs. The second level examined processes. And so on. While these were cumulative, it can be seen that they do not measure progression on one dimension.

Value. Does accreditation result in improved health outcomes or operating efficiencies? As with CME, the evidence is mixed and is even less positive. Weak, but positive, support comes from neighbors within the region, but bear in mind that these studies were conducted while the hospitals were seeking accreditation. Lebanese nurses thought accreditation was useful for improving quality.[5] Patient satisfaction was higher in Egyptian hospitals under-going accreditation than in control hospitals.[6] Stronger results – but hardly conclusive – were unearthed after some digging in the US. Rural accredited hospitals produced superior health outcomes for some diseases than others, although the association did not hold up for urban hospitals.[7] These studies are representative of the tenor found throughout the literature; there are positive signs, but strong and definitive evidence is still lacking. In fairness, the association between accreditation and health outcomes has not been rigorously examined so the absence of positive research results may be owed to the absence of research. It should also be noted, many of the things checked in an accreditation survey do not have a direct relationship to health outcomes (indirect, yes). PHC facility quality certification in Indonesia was based only on provider compliance with best practices. In that program we found a strong association between quality certification, health outcomes and operating efficiency.[8] This suggests that as accreditation standards more closely reflect best practices in diagnosis, treatment and counseling, the association with improved health outcomes will go up. There may be a lesson in this for the Palestinian health sector as foreign accreditation standards are adapted.

External Assistance

This has been touched upon above with respect to international accreditation. These same organizations – JCI, CHKS, Trent, Accreditation Canada – all stand ready to help The Pales-

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[5] El-Jardali F, Jamal D, Dimassi H, Ammar W, and Tchaghchaghian V. "The impact of hospital accreditation on quality of care: perception of Lebanese nurses." *International Journal of Quality in Health Care*. 20(5): 363-71 (October 2008).

[6] Mahi Al Tehewy, Bssiouni Salem, Ihab Habil and Sayed El Okda. "Evaluation of accreditation program in non-governmental organizations' health units in Egypt: short-term outcomes." *International Journal for Quality in Health Care* 21(3): 183-189 (2009).

[7] Morlock L, Engineer L, Engineer C, Fahey M, Clark R, Shore A. "Is JCAHO Accreditation Associated with Better Patient Outcomes in Rural Hospitals?" *Abstract of the Academy of Health Meeting* 22: abstract no. 4224 (2005).

[8] The consultant directed this project which covered 1,488 health centers and is familiar with the results. Treatment practices improved, polypharmacy declined, repeat visits for disease recurrence declined, and facility utilization climbed.

tinian health sector along the path toward a functioning accrediting system (for a price). Not all the services are the same. For example, HCAC in Jordan is fond of boasting that it is ISQua accredited. In fact, ISQua has accredited HCAC's hospital standards, not HCAC as an accrediting organization. There are similar bodies in Egypt and Lebanon. Any of these might provide useful assistance in adapting standards, training surveyors and conducting mock surveys, whether they enjoy ISQua's blessing or not. (HCAC, perhaps sensing that their most marketable product is the approved hospital standard, has become coy about sharing the document.)

The decision point here is to decide *how much reliance will be made on external sources and, if any, which sources.*

To this point assistance only for the accreditation system has been considered. What of the facilities? There are organizations that can provide a range of services to a facility as it seeks accreditation. Conveniently for subcontracting purposes, Loma Linda University worked with a hospital in China in much this way. A second decision point: *Should external assistance be procured to help individual hospitals achieve accreditation?* The arguments in favor of external assistance are easy to anticipate:

- Accreditation is a staff-intensive activity and in a voluntary system the incentives, for both the facility and the staff, are not evident.
- Much of the required documentation will be new and staff may perceive the learning curve as long. For both of these, the presence of experienced external assistants may relieve some of the load, quicken the pace of learning, and provide the satisfaction that comes from working with a new colleague.
- The likelihood of passing the survey is increased. In Cambodia we found that as little as ten person-days of assistance to a PHC facility improved the pass rate from 55 percent to almost 90 percent.

The primary argument against external assistance is cost. It might be feared that another disadvantage would be reduced opportunities of hospital staff to learn – a valid concern – but good technical assistants can avoid this pitfall. Loma Linda staff who worked in China claim that they balanced their inputs to ensure organizational learning while reducing the disruption that an impending accreditation survey entails.

Obstacles

Resistance. The down-side risks of failing an accreditation survey are limited in The Palestinian health sector (embarrassment, mainly) but accreditation requires a lot of work of facility staff. It takes staff time and compliance with many new requirements that will cost money, training, and distraction from other activities. Critics charge that this intensive period of attention to accreditation standards in US hospitals has an unfortunate corollary effect. Hospital staff only pay attention to the standards when a survey approaches; the effect on operations the rest of the time is small.

The simplest way to minimize these inconveniences is to outsource some of the work as mentioned above.

The upside, in the absence of medical tourism, is largely prestige. Far stronger incentives can be marshaled if the health insurance program elects to refer only to accredited hospitals, or the staff of accredited facilities receive tangible benefits (e.g., priority for overseas training, salary bonuses, better working conditions). These are worth considering.

Capacity constraints. There are two short-term constraints to be considered. Obviously accreditation is a new process and facility staff will have much to learn. A judicious mix of

study tours and external assistance can alleviate this. The other constraint is the investment required to bring facilities up to accreditation standards. Decide: *The Project will have to establish its own policies regarding how and where Project resources will be used to resolve infrastructure and equipment lacks. MoH or all sectors? Capital improvements? Improvements with revenue generating potential?* And so on.

Sustainability. This is not as big a problem as in the other two areas, but it is not negligible. The costs of retaining accreditation, should, in principle, decline with subsequent surveys. If accreditation improves revenue (referrals, ability to charge higher fees) the sustainability issue is further alleviated.

ROUTING AND SCHEDULE

We will start with three preconditions that can be addressed concurrently: basic facility licensing, QI and orientation.

Basic licensing.

Dr. Al-Wazani is working to complete the basic legal substructure for licensing and Project staff have participated in the two bylaws already drafted. To increase the likelihood this activity will move forward, the following can be undertaken:

1. Select a few relevant professions and facilities to work on. Finalize drafts and start them through the approval process (described earlier).

2. Train inspectors to implement the licensing standards.

3. *Decide how the Project will field requests for support to redress infrastructure and equipment deficiencies that prevent a facility from receiving the basic MoH license*. It could be argued that the Project would be willing to help reach accreditation standards, but the MoH should, at least, be willing to use its own resources to bring facilities up to its own basic standards. Or, the opposite argument: the Project will support provision of basic care in The West Bank and Gaza; if any facility (in any sector) wants to proceed above that level, they should do so with their own resources.

4. Support inspection of hospitals and health centers in all sectors. Participate in the "policy dialogue" on how to deal with those facilities that fail to meet standards. We should expect remedial action of some kind.

Quality improvement.

Nearly all accreditation standards require an on-going QI program in the facility, presumably one with some track record of accomplishments. Each MoH hospital has, at least in name, a QI committee.

5. In the absence of staff in the MoH QI Department, this requirement may give focus for the Project's own QI activities. Project staff could contact and mobilize each MoH hospital QI team and work out a program of coaching and support.

6. In conjunction with the accreditation familiarization workshop (below) conduct a strong training module on QI for attendees from non-governmental facilities.

7. Continue work with the MoH QI teams and coach the QI teams from the non-governmental facilities that appear most committed to accreditation.

Orientation.

It is reported that few in the hospitals have a clear picture of what accreditation entails. The process of explaining it can also educate the explainers and elicit useful suggestions for improving the process.

8. Before the process can be explained, it has to be known. The starting point is to resolve the following questions:

a) Decide: *Which facilities will be covered? Hospitals, health centers, labs, etc?*

b) Decide: *Will the accreditation program be mandatory? If so, what are the consequences of failing to achieve accreditation? Or, to seek accreditation? If it is voluntary, what are the incentives for participation?*

c) Decide: *Where will accreditation authority reside? Which national entity? Will there be support for facilities pursuing international accreditation?*

d) Decide: *What will be in the standards?*

e) Decide: *What is the timetable?*

f) Decide: *Will there be intermediate steps to accreditation?*

g) Decide: *What is the appeals process for disputing a finding?*

And so on through operational and strategic issues of concern to facility directors and staff. It is probable they will raise questions that require an answer and had not been thought of before.

9. Conduct workshops for all facility directors in the sector(s) where the accreditation program will be implemented. Add the QI orientation module for non-governmental facilities. It is assumed that the QI teams in the MoH hospitals have some notion of QI. This could be mistaken.

Implementation.

Some of the following can/should begin before the above steps are completed. Implementation requires a) creating the accrediting body, b) formulating the standards, c) assisting facilities as they prepare for the survey, d) conducting surveys and scoring facilities, and e) offering remedial support for facilities in need, and deserving of such. Unless otherwise noted the activities in this area are sequential:

10. Create the accrediting body or expand an existing one. If not an existing organization, select board members from stakeholders, orient them through study tours and technical assistance.

11. Support creation of the accrediting body (staff, facilities, training). *Decide on amounts and kinds of external assistance.* Bring in external assistance as decided upon.

12. Finalize the standards. Adapt regional standards to The West Bank and Gaza. My own preference is for increased emphasis on compliance with best clinical practices.

13. Recruit and train surveyors. Conduct mock surveys.

14. Assist facilities in their preparation for the survey. Challenge their self-assessment findings (usually optimistic). *Decide on how much material support should be offered at this juncture.*

15. Conduct surveys, with Project support.

16. Again, *decide how much material support will be provided to help facilities meet standards.*

B3. Re-Licensing

No one ever thought re-licensing would be easy, but it may not be as far a reach as first feared. The major players in the health sector are on record in favor of mandatory re-licensing, linked to satisfaction of CHE requirements: the Minister, Director of the CME Directorate, Director of the PMC, Secretary General and Board Members of the Medical Association, Medical Director of UNRWA, Director of Makassed Hospital, Director of the Najah University Faculty of Medicine. No one has expressed opposition and it has been my impression that the attestations of support have been genuine. Illustrative of the broad support for re-licensing, the Medical Association is trying to figure out how to impose a 26 hour annual CME requirement on GPs.

Destination

End point. There are three broad approaches to assessing or maintaining medical competence and renewal of the license: periodic formal examinations, a review of credentials by a committee, and participation in continuing health education (CHE). Many health professionals find the last, CHE, is the most secure and predictable. Staking your career on a day-long examination is risky. Who knows what a committee might do. But complying with CHE minimums only requires attention to the calendar and attendance at the occasional course. The basic question is: what will be the basis for re-licensing. The UK has five factors, but has not defined what is required on them. The US has different requirements by profession. Consistent with the observation that professionals will most welcome the low risk method offered by meeting CHE minimums, it has seemed likely that The Palestinian health sector would adopt that. There may, however, be need for examination to recertify; this would be useful for professionals who had, for whatever reason, failed to certify through CHE attendance.

Most of the discussion has focused on physicians, and given their capacity to influence the quality of care that focus is appropriate. There is also the expectation that if re-licensing can be successfully implemented with physicians the other health professions will fall into line. The first major division has been GPs vs. specialists. In an ill-fated move two years ago Jordan tried to impose re-licensing requirements only on specialists, despite the widely believed poor performance of many GPs in the country. One reason cited for the failure to secure approval in Jordan was the illogicality of imposing requirements only on the better qualified providers. Decision point: *Which professionals will be required to demonstrate professional development to retain their licenses to practice?* The arguments are predictable. It will be alleged, as in Jordan, that specialties are experiencing the most rapid change and specialists are those most in need of constant updating. Contrarily, it will be alleged that general medicine is moving as fast, and most care is provided at that level. My recommendation is to require re-licensing of all physicians and side-step this argument.

A second decision addresses whom within the profession. Jordan, after misfiring, has scaled back ambitions and now is vetting a proposal to impose re-licensing requirements only on future physicians. Decide: *Will a re-licensing requirement apply to all or only to future healthcare providers?* The arguments here are political expediency vs. patient welfare. Another recommendation: Given that future generations of physicians are already being held to a higher standard by the PMC testing process, the greatest need for mandatory re-licensing is with current practitioners. Given that, it will still probably be necessary to phase in the re-licensing requirement over a few years. The number of those years will be influenced by the amount of subsidized CHE is available and the number of contact hours required.

There are a number of operational decisions mentioned in other Project documents which will not be reviewed here (How many credit hours? How demonstrated? Duration of license? and so on.)

Value. Regarding the contribution of re-licensing to improved healthcare, reference is made back to the discussion on value in the CHE section. You may recall that, with some qualifiers, it was found that participation in CME was associated with better health care and better health outcomes. Since CHE is the basic requirement for re-licensing, we may extend those findings to support the value of re-licensing.

Incentives. We all know the problem: fear of loss of license and livelihood. We have talked around this above, usually in terms of phasing in requirements and making CHE so abundantly and cheaply available that it will be very easy to meet the requirements. However, the successful resistance mounted by the pharmacists to re-licensing requirements a few years ago is one cautionary reference point.

Against this fear of loss of license, positive incentives such as professional pride or respect of colleagues and patients are weak counters. The surest path is to reassure providers that the re-licensing requirements can be met easily and routinely. Confidence in the system is strengthened by positive experience in obtaining needed credits. This takes us back to the need to put in place an impressive offering of credit earning opportunities through subsidized courses, internet learning in learning labs, accredited discussion groups, publication opportunities, and on through the list of qualified CHE creditable activities.

Implementation. In light of concerns about the political implications, it is easy to lose sight of the implementation issues. *Where will the program be housed*? The Ministry is a good possibility as it issues the basic license to practice. But the PMC issues licenses for specialties so they might have a role. The Syndicates also make recommendations on the basic license to practice. In the absence of a change in legislation, the MoH has the clearest mandate to suspend or revoke licenses and, therefore, is the most likely candidate, but given the gravity of the decision to revoke a license, a final review panel might be established with representatives from several involved organizations.

The details of implementation start with creating a registry of health professionals, by profession. This will be a long and difficult task. Software will be needed to record compliance with standards (these packages are commonly found in use at universities). Staff will need to be hired and trained.

EXTERNAL ASSISTANCE

The technical issues to which international expertise might contribute are few: setting up the documentation system, generating current rosters of practitioners, a system to notify practitioners of their status, and so on. That, said, there are two other areas where an outsider might help. First, in the public debate, it might be useful to bring respected figures from both Western and reference societies to testify to the importance of re-licensing. The UK has finally adopted re-licensing and someone from there might be able to provide a convincing explanation of the rationale. This will not convert opponents, but it does force them to choose their arguments carefully lest they be accused of indifference to patient safety and welfare. Second, given the limited experience The Palestinian health sector has been permitted in drafting legal codes, external assistance might accelerate the preparation of draft by-laws and instructions. There seems to be a tendency to draft laws that are a collection of declarative statements. The notion of acknowledged exceptions, special cases, triggers, opt-outs, and so on may not come naturally to those charged with drafting these documents. This is written in light of comments that have made about special circumstances that do not

fit well with re-licensing. The obvious response, where these special circumstances are legitimate, is to write those special circumstances into the laws or bylaws.

Obstacles

A further category of resistance is added in this area, the legal foundation. The battle over re-licensing may be waged via legal procedural maneuvering. Apparently the 1999 attempt to introduce CME requirements may have fallen victim to such.

Legal foundation. A frequently cited obstacle is the need to obtain a legal basis for mandatory re-licensing. The process and options for securing a solid legal foundation for re-licensing were described earlier. The principal points are:

- The MoH grants the basic license to practice general medicine. The PMC grants licenses to practice specialties. Note that the MoH will not grant a license until the PMC attests the applicant has passed the general medicine examination.
- The Public Health Law gives the MoH authority to grant, temporarily suspend and permanently revoke licenses to practice. The causes for suspension or revocation are not specified. Medical and auxiliary health professions are covered by these provisions.
- The Palestinian Medical Council Law is empowered to grant licenses to practice a specialty, but the law is silent on revoking or suspending a license. The PMC Law does grant the PMC to "determine certificate validity."

The legal bases are not as solid as one would want if a confrontation is anticipated. That would indicate the need to issue bylaws to clarify the provisions just cited.

Resistance. Despite the broad support among leaders in the health sector for re-licensing, victory is not guaranteed. What may be anticipated is that opponents will not openly challenge the merits of re-licensing. To do so will invite charges of indifference to medical progress and patient welfare. Rather, count on hearing about peripheral issues such as entanglements with Jordanian or Egyptian Medical Associations, pension schemes, and so on. The opponents will state their own unwavering dedication to professional development, but object to the inequitable way the re-licensing provisions would be applied. In some instances these peripheral issues will be real and can be dealt with in the draft bylaw (see this under External Assistance above). In other instances the pressure has to be kept up on the opponents to provide proof of their declarations in favor of professional development. It will be useful to have data in hand which demonstrate how little professional development now goes on in the Palestinian health sector.

Capacity constraints, These have been discussed in the section on CHE.

Routing and Scheduling

Scheduling, or phasing, is especially important for re-licensing. There seem to be two schools of thought: One holds that the decision on re-licensing be deferred until the CHE program has successfully demonstrated to all how easy it is to meet the requirements. The argument continues that most healthcare providers will find they have already amassed enough credits to re-license when, a few years down the road, the re-licensing requirement is formally proposed. The other line of thought begins with the observation that we are not dealing with naïve people and they will immediately divine the purpose of certifying trainers and courses, setting credit hours, and recording credits. They will not be fooled, and they will fear something sinister is underway, lest why else the secrecy? This leads to the conclusion that there should be immediate work on bylaws that take effect in a few years. It is

honest, transparent, and lets healthcare professionals figure out how to comply. Or, so the argument runs.

There is perhaps a middle path which is to make a commitment to re-licensing and to schedule an orderly series of hearings, lectures, study tours, etc. over a 2-3 year period while option A (lots of training opportunities) plays out. This middle path assumes that formal policy changes can more easily be agreed on in a few years when healthcare professionals have become more comfortable with the system and decision-makers are amply informed. There are also dangers associated with this middle path: 1) A decision deferred once (we'll decide in a few years – meanwhile let's keep talking), is easily deferred again, and again, and again. 2) Current momentum will be lost.

Phasing

1. The first step and decision, therefore, is: *Start work on defining the formal re-licensing structure now through new bylaws or instructions, or defer that until later?*

There is embedded in this a precedent question that will have to be addressed. Decide: *Will an instruction suffice to mandate re-licensing requirements? Or will a bylaw be needed?* This is a legal question requiring expert input.

Whether an official policy change is sought now or later, the steps are essentially the same with the exception that a deferred introduction of the change permits more time to build support through more workshops, forums, visiting lecturers, press releases, and so on. As noted, it also permits more time for the opposition to organize. And more time for supporters to lose interest and move to other causes.

Building support

The following can be conducted concurrently:

2. Hold a series of small workshops, initially with friendly elements, to discuss the needed change and elicit suggestions.

3. Prompt influential figures, both in health and out, to speak to the need for maintaining professional currency.

4. Collect and publicize data on the lack of recent training by providers. Walk a careful line as you do not want to undermine confidence in the whole health system, but rather, signal that there are "weak spots" that exist because the unmotivated are exploiting the absence of regulation.

5. Be alert for horror stories of malpractice that can be linked to untrained providers. This, again, should be done responsibly. The intent is to remind everyone that there is room for improvements and peril in not making those improvements.

6. Do not, at any point, indicate that this change is other than inevitable.

Drafting code

As noted earlier, care should be put into drafting any new regulations.

7. Dr. Al-Wazani's work offers an opportunity to simplify future work. While it might be premature to insert complex and complete re-licensing provisions into the bylaws he is trying to complete this year, it might be possible to place a clause in his bylaws that lowers future legal barriers. For example: "The MoH may issue instructions requiring practitioners to demonstrate their continued professional competency as a condition to practice medicine/nursing/physiotherapy, etc." The net effect of a clause like that in all professional bylaws

is to permit the Ministry to impose CHE requirements, or periodic board exams, via instruction. Note that an instruction still has to earn the approval of the Cabinet.

8. Whether instruction or bylaw, the final regulation should be comprehensive, including special provisions, exceptions, and any other concessions that need to be made to legitimate concerns of providers. Once it has been amply vetted, it may be sent through the approval process.

Implementation
At some points it will be necessary to set up the management structure.
9. Decide: *Where will the re-licensing program be housed?* Probably in the MoH as they have the power to revoke a license, but broader participation may be indicated when those kinds of decisions are taken.

10. Establish the office, start work on compiling the professional registries, train staff.

11. No law is valid until enforced. It would be helpful to signal the sincerity of the government in enforcing the re-licensing provisions by making an example of a violator. Just as it is often good to start with a warning shot if you are trying to avoid a full-scale conflict, the first violator prosecuted could be guilty of a minor offense and receive correspondingly minor punishment, such as temporary suspension of license to practice until CHE requirements have been fulfilled. The danger of too light a sanction is that it will become a precedent.

C. Next steps

The proposed next steps are driven primarily by the enthusiasm and awakened expectations of counterparts. As noted in the Recommendations, a large number of decisions are needed to initiate the process. As a consequence, the first order of business for the Project is to facilitate making those decisions. Given the prevailing climate of relative comity, it may be possible to bring stakeholders together in well-structured events to either take those decisions, or to make strong recommendations to decision makers. Here consider three aspects: Where does decision-making authority lie? Who are the most interested and influential stakeholders? How should the decisions be taken?

<u>Who has the authority to decide?</u>
As is often the case, authority is divided among those who – in a few cases – are officially designated to make the decision, those who control enough elements of implementation to carry out the decision (or sabotage it), and those who pay.

Starting with the last: <u>who pays</u>. In all three components the Project can wield great influence over the decisions. In the absence of another well-financed project, Flagship can effectively veto major initiatives in CHE and accreditation. While small programs might be undertaken in these two areas without the active support of Flagship, it is difficult to picture CHE or accreditation activities that would have much reach or impact on the quality of care in Palestinian health sector.

Another paying organization that has the potential to influence adoption of accreditation and re-licensing is the National Health Insurance program. Although this is still in formation, a clear expression from them that they strongly favor reimbursements only to accredited facilities and re-licensed providers would carry weight.

<u>Designated to decide</u>. The other veto holder is the government, through the MoH, on mandatory accreditation and re-licensing. Both of these will require, at a minimum, new instructions from the MoH, and, more likely, new bylaws. CHE and voluntary accreditation could go forward – and CHE is doing so – without active endorsement by the government. Beyond this it is unclear that there is a designated locus of decision making authority. Looking at examples elsewhere, the principal actors in the health sector have arrived at a consensus to establish independent facility accreditation and CHE accreditation bodies, granted they were spurred by third-party payer interest. Government involvement waxes and wanes. It has increased in the last two decades in the US as the government became a major purchaser of care, but that has led primarily to creation of alternative bodies for accreditation and not tighter control over the existing ones.

<u>Control over implementation</u>. Here the field opens up.

CHE. Those with influence over implementation of an expanded CHE program can be divided among providers and consumers. For both, the ultimate decision to support CHE will be based largely on perceptions of costs and benefits. On the provider side are the major teaching hospitals and schools of medicine. Many other CHE providers may come forward, but these two have a large enough political presence to gain them a seat at the table. The end consumers of CHE are the 33,000 healthcare providers in The Palestinian health sector; finding representatives who can speak for them is a challenge. In theory the professional associations are the designated representatives and they should be included; however, it is unknown whether decisions they endorse will be carried out by their memberships. One group that does represent consumers are the major employers of health professionals: notably NGOs and hospitals. Since they will be paying for the training and probably providing time off for staff to attend, they will have the keenest

interest in the costs and perceived utility of CHE. To state the obvious, they will want low cost training that adds value to staff. In practice this means they would want input into the course offerings.

Accreditation. Since an accreditation program implies additional costs and effort, every hospital director who manages the budget and every staffer who is asked to work on accreditation can affect implementation. Experience in the region indicates how effectively an uncommitted hospital management can derail an accreditation program. It is unclear how much enthusiasm for accreditation can be generated by inviting participation of these people in the initial decision- making. Perhaps some involvement in the early discussions will limit grounds for later complaints that they had no voice. Of greater practical value is inclusion of hospital management in the design of the accreditation program.

Re-licensing, The actual implementers will be an organization such as the PMC or MoH. At issue will be the degree of zeal they bring to the task. Recall that there is currently re-licensing of nurses, but no one could cite an instance of a nurse being denied renewal. If a decision on re-licensing is to be effective, the staff of the responsible body will have to be ready to apply the rules neutrally and consistently. They are more likely to do this if they understand they will be supported when they make tough decisions. There seems to be no advantage in including them in initial decisions.

From the foregoing it appears that, at a minimum, those who need to participate in the initial decisions are:

CHE. Flagship, MoH*, PMC, major NGOs, teaching hospitals, schools of medicine and professional associations (since this is a prelude to re-licensing).

Accreditation. Flagship, MoH, and directors of representative hospitals from all three sectors. The PMC and National Health Insurance Program could be invited as "expert witnesses."

Re-licensing. Flagship, MoH, PMC, and professional associations.

<u>Who are the interested and influential stakeholders?</u>
These have been identified above. For clarity they are listed below:

CHE. Health professionals, professional associations, MoH, PMC, managements of major NGOs, major hospitals, schools of medicine.

Accreditation. Hospital management and staff of any sector where accreditation will be applied, MoH, PMC and National Health Insurance Program.

Re-licensing. Health professionals, MoH, PMC, and professional associations.

<u>How should the decisions be taken?</u>
The Flagship Project should set the schedule and strongly suggest who participates; however, the key decision makers should determine how much ground to try to cover in each event and what to include in the meetings, such as presentations from stakeholders and external experts. Once those broad outlines have been arrived at it is fair for the Project, as host and co-equal, to overlay an organizational framework on the proceedings. A sequence such as the following might move deliberations forward:

1. Meet singly with decision makers to elicit suggestions on who should participate in the first discussions on the major decisions for each component.

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* It is understood that the MoH is not monolithic and a different person or team might be involved at different points in the processes.

2. Host the first meeting of those most consistently recommended in the preceding step. Lay out the series of decisions required – somewhat as found above –and the schedule that has to be maintained in order to take full advantage of Flagship resources. Secure agreement on who will be involved in the next few decisions and what inputs are needed to inform those decisions. It may be useful at this initial meeting to establish a steering committee for each of the three components. Flagship should retain the role of secretariat throughout. If expert advice is needed, Flagship should secure it. If a quick study is of value, again, Flagship should carry it out. No one else has the time, resources, or, initially, the vision.

3. Once the requested inputs have been assembled (there could be none) the second meeting should focus on the action plan. We have heard suggestions that a series of workshops around the country would be useful to sell the concept and hear suggestions for improvement. Those workshops might be in the action plan. Alternatively, the participants may be ready to make decisions. It is noted that the IDP already includes action plans for the three components, and although events have overtaken some of the planned activities, they still provide a good point of departure.

4. As a point of process, it is likely that consensus will be needed on the major decisions. To be clear, consensus as used here means that most of the participating members favor a course of action and no one is seriously against it; it does not mean unanimity.

<u>Work in progress</u>
While discussing next steps, the accreditation policy drafted with Dr. Al-Jawhari should be kept moving forward. This may become a useful talking paper. Dr. Jawhari's departure for Europe interrupted work and he should discuss the paper with others in the Project to further improve it.

ANNEX A: TERMS OF REFERENCE

PALESTINIAN HEALTH SECTOR REFORM AND DEVELOPMENT PROJECT

(Flagship Project)

Position Title: Continuing Education and Accreditation Policy Advisor
Job Classification: Short-Term US Expatriate Consultant
Reporting To: J. Thomas
Date of Assignment: ASAP
Total Number of LOE: 60 Days

Flagship Project Objective

The Flagship Project is a five-year initiative funded by the U.S. Agency of International Development (USAID), and designed in close collaboration with the Palestinian Ministry of Health (MoH). The Project's main objective is to support the MoH, select non-governmental organizations, and select educational and professional institutions in strengthening their institutional capacities and performance to support a functional, democratic Palestinian health sector able to meet its priority public health needs. The project works to achieve this goal through three components: (1) supporting health sector reform and management, (2) strengthening clinical and community-based health, and (3) supporting procurement of health and humanitarian assistance commodities.

The Flagship Project will support the MoH implement health sector reforms needed for quality, sustainability, and equity in the health sector. By addressing key issues in governance, health finance, human resources, health service delivery, pharmaceutical management, and health information systems, the Ministry will strengthen its dual role as a regulator and main health service provider. The Flagship Project will also focus on improving the health status of Palestinians in priority areas to the Ministry and public, including mother and child health, chronic diseases, injury prevention, safe hygiene and water use, and breast cancer screening for women.

Technical Background and Purpose/Need for ST Consultancy

The development of an objective, externally validated, transparent accreditation process represents a commitment to quality care by all stakeholders (MoH, management and staff of health facilities, including NGOs and private sector) and informs the community that quality care is provided at a particular facility. Developing a health facility accreditation program addresses the elements of efficiency, quality, access, and sustainability.

Developing a health facility accreditation program was identified by the MoH during its self-assessment conducted in late 2008. The MoH, with support from the Flagship Project, then developed an institutional development plan (IDP) module and action plan to develop a health facility accreditation program. A first step to this is to develop/refine a Project Accreditation Readiness Tool as part of the plan to support building a Palestinian accreditation system.

Likewise, the Ministry of Health IDP calls for the development of a continuing medical education system for all levels of the MoH, that eventually will be required as part of a planned licensing and re-licensing system for all Palestinian health professionals, which in turn ties to accreditation of all facilities.

It was envisioned that the accreditation, continuing education and licensing systems would be administered by non-governmental organizations such as the Palestinian Medical Syndicate and Palestinian Schools of Health Sciences, with input from the Ministry of Health.

To further the inter-related tasks noted above, the Flagship Project seeks a highly-experienced international consultant in health policy, accreditation and continuing education to act as the focal point in planning the overall national strategy and direction for the planning of these tasks over the next four years. The Consultant should be aware that Flagship plans to contract with an independent international accreditation consulting firm to do the actual design of the actual accreditation system and its components, and that other Flagship partners will assist with the design and implementation of the components of the continuing education system.

ST Consultant Objectives:

1. The CME and Accreditation Policy Advisor will work with Flagship staff, Ministry of Health counterparts, representatives of the Medical Association, Palestinian Health Council, NGOs and other institutions to develop a strategy and timeline for national systems strategy development.
2. S/He will initiate a process of planning the development of CME and health facility accreditation systems in conjunction with the above-mentioned institutions,
    - Examine existing tools and criteria under development.
    - Review Best Practices in other countries, WHO and other sources as references.
    - Develop strategies and policies and procedures for applications.
    - Encourage culture and style of thinking that improves the level of preparedness at the facility level
3. S/he will build MOH capacity to develop a multiyear implementation plan which works toward Nation-wide adoption of a health facility accreditation system and continuing medical education system.

Specific Tasks/Deliverables

Technical

- Review existing standards of care from accreditation institutions (including JCI standards for accreditation).
- Build working relationship between MoH and Palestinian Medical Council and other non-governmental stakeholders to further development of strategies for implementing Palestinian accreditation and continuing medical education systems.

A. Develop Health Facility Accreditation tools, Policies and Standards

- Analyze existing accreditation policies, plans, assets, institutional structure, capabilities, and practices and those under development at the Ministry of Health.
- Guide a multi-stakeholder accreditation Working Group at the National level with the aim to:
    - Examine current policies and models of health facility accreditation in The Palestinian health sector, regionally and internationally
    - Identify strategies to be undertaken by the MOH to establish laws and policies supportive of a Health facility accreditation system
- Build capacity of Palestinian Health Ministry and Flagship counterparts to:
    - Develop strategy and timeline for Health Facility Accreditation system.
    - Develop strategy and timeline for Continuing Medical Education System

- o Help in the design of necessary workshops and trainings for all institutions targeted for the accreditation and continuing medical education processes that enhances their capacity and level of preparedness.

B. Develop Linkages with Other Accreditation Initiatives:

1. Coordinate activities with the health facility accreditation initiatives underway or under development in The Palestinian health sector.
2. Review and evaluate existing policies and models of accreditation regionally (e.g. Jordan, Lebanon, UAE) and internationally.
3. Assist the MOH, where possible, to identify funding agencies and NGOs to actively and enthusiastically support a system of Accreditation.
4. Assist monitoring team to design and develop monitoring and reporting tools that reflect guidelines and protocols benchmarks.

C. Develop a Multi-Year Implementation Plan

1. Develop an action plan to create health facility accreditation standards and competencies in alignment with the ongoing efforts of the MOH.
2. Review and finalize a multiyear implementation plan for development of Health facility accreditation system through the active engagement of the counterparts.
3. Ensure that measures are undertaken so that background information and achievements are incorporated into the Ministry of health MIS and the Health Facility Profile database.

Main Outputs

- ➢ Report on Policies and Standards, CME and Accreditation
- ➢ Multi-year implementation plan, CME and Accreditation
- ➢ Draft trip report and presentation of key findings to the Flagship team delivered before departure from country

Education, Qualifications and/or Equivalent Experience

- Physician, RN, Ph.D. or graduate degree in public health or a related field.
- A minimum of 5 years experience working with developing health facility accreditation systems.
- Knowledge and experience in developing health services in the West Bank and Gaza, the Middle East or conflict/post conflict settings.
- Excellent oral and written communication skills.
- Ability to work with and communicate with a wide variety of people.
- Excellent writing and communication skills in English. Written or verbal communication skills in Arabic a plus.

ANNEX B: ITINERARY

29 August 2009. Depart Atlanta, GA.
29 August. Arrive Ramallah, West Bank via Tel Aviv, Israel.

25 September. Depart Ramallah, West Bank.
26 September 2009. Arrive Atlanta, GA via Tel Aviv, Israel.

ANNEX C: CONSULTANT CV

MICHAEL H. BERNHART

Dr. Michael Bernhart has over 20 years of experience directing successful social development programs, primarily in health care. He is an acknowledged authority in quality improvement of health care and is recognized for his contributions to social marketing, behavior change, policy reform, community promotion, and training innovations.

Program management. Dr. Bernhart has directed six major programs during his career, five of them in health services. He directed one of the first projects to improve the management of family planning programs, funded by Ford Foundation in Central America, and, more recently, programs in Indonesia, Jordan and Cambodia. Every program surpassed its objectives.

Social marketing. Dr. Bernhart designed and directed a social marketing project that increased the contraceptive market share of the private sector nine percent, reduced discontinuation one-third, doubled condom sales, shifted detection of breast cancer from late to early stages, and encouraged thousands of abused women to seek protection and counseling.

Quality improvement. Dr. Bernhart implemented the largest quality improvement program in primary care (Indonesia) and has authored publications on quality improving models, incentives for quality, and patient satisfaction. His work in Indonesia produced a three-fold increase in compliance with internationally accepted standards of health care for seven health interventions. These improvements in service quality were accompanied by a steady five percent annual increase in facility utilization, declining poly-pharmacy, and reduced costs per client.

Training innovations. Dr. Bernhart has a long history of innovation in education. He produced educational television series on international economics and computer programming. With colleagues at USAID and CDC he developed the computer assisted training program for WHO's Integrated Management of Childhood Illness that, in field trials in Africa, was proven as effective as the conventional course and reduced costs by one-third.

Behavior change. Dr. Bernhart implemented the largest national mass media campaign in Jordan which included community outreach, 52 televised public service announcements, a thirteen part television series on women's issues, millions of brochures, educational calendars, etc.

Community promotion. Dr. Bernhart and counterparts developed a community outreach program that visited 3,600 Jordanian women per day in their homes, promoting family planning, early detection of breast cancer, and reduction of domestic violence.

Policy reform. Dr. Bernhart, has moved policies forward in all of the projects under his direction. Representative changes achieved: infection control policies (HIV and TB); development and implementation of national evidence-based standards of health service; IUD insertion by midwives; institution of fees for services; free sterilization services; condom sales outside of medical facilities/pharmacies; pre-paid reproductive health and maternal services; and elimination of duties and taxes on contraceptives.

PROGRAM MANAGEMENT

Dr. Bernhart has directed six major programs, three smaller ones, and published on the management of development programs. The three most recent programs are described in detail.

Program Management Experience

Country Director, Chief of Party, Health Systems Strengthening/Cambodia (07 - 08). Joined project in its final year. Project worked at the national level on policy reform, at the provincial and district levels on strengthening management capacity, and at the service level on improving delivery of TB and HIV/AIDS services, increasing general service quality, and removing access barriers for the poor. Also a small avian influenza component.

Major components:

- HIV/AIDS. Policy development for national program. Support to VCCT and PMTCT facilities, including construction/renovation and equipping, training for clinicians and counselors, counseling and testing for pregnant women, safe delivery, ARV prophylaxis, counseling and support for safe infant feeding practices and family planning counseling or referral. Support to HIS and supervision systems. Emphasis on coordination with TB and improved cross-referrals.
- Tuberculosis. Development and expansion of private provider referral program to include village practitioners. Monitoring of lab quality and technical assistance. Support to supervision and information systems. Creation of educational materials.
- Health financing. Identification of those below poverty line, negotiation with MoH facilities on payment rates to purchase services for the poor, negotiations with donors to expand program.
- Quality improvement. Development of standards of service for hospitals and health centers, coaching to facilities to improve service quality, and assessment and reassessment of 20 hospitals and 64 health centers.
- Systems strengthening. TA and coaching to provincial and district MoH staff. Annual assessment of management capacity and follow up assistance.
- Avian influenza. Established isolation wards and improved infection control in four reference hospitals. Trained epidemiologists. Produced training and educational materials.

Results:

- HIV/AIDS. Increased number of women tested in PMTCT program, number of referrals to VCCT, percentage of cross-referrals for TB screening, percentage of HIV+s on ART, and number of PLHA attending support groups and receiving food supplementation. Number of PMTCT and VCCT centers doubled; number of health centers offering testing and counseling increased 130 percent; similar large increases in numbers receiving palliative care, ARV prophylaxis, and counseling on breastfeeding and family planning. Policy success in mobilizing interest and resources for infection control which culminated in two national guidelines on infection control and a large budget commitment to correct infection control problems in ten percent of the facilities in the country.
- Tuberculosis. Managed successful private to public provider referral program (few go to public facility with TB symptoms); extended private – public referral program to include informal providers (*pet phum*). Increased case detection by 24 percent in provinces where introduced. *Pet phum* referrals especially productive; 23 percent of referred patients found BK+, more than double the norm. Led the adoption of four-fixed-dose drug and trained all providers in supported provinces.

• Health financing. Coverage of poor doubled to 1.4 million during Dr. Bernhart's leadership of the project. Utilization rate of health care services by the poor, after covered by benefits, doubled. Payments to facilities led to near doubling of provider incomes. Success of program attracted other donors and contracts were secured with three other donors during the period.
• Quality improvement. Standardized quality assessment instruments for hospitals and health centers adopted by MoH. MoH mandated country-wide use of the assessments. These instruments, when conducted in 20 hospitals and 64 health centers, documented large improvements in service quality, on average 32 percentage points for hospitals and 38 points for health centers.
• Systems strengthening. As measured by project's management capacity assessment instrument, the district offices improved by 47 percentage points and the provincial offices by 39 percentage points. Instrument subsequently adopted as the national standard for measuring management capacity.

Chief of Party, Commercial Market Strategies/Jordan (99-05). Designed and directed a social marketing program in reproductive health care, early detection of breast cancer and reduction of domestic violence.

Major components:

• Behavior change. Door-to-door outreach to 70 percent of the nation's couples of reproductive age. Television promotion of family planning that promoted responsible paternity, debunked rumors, addressed religious concerns and gender preferences, and explained methods (52 PSAs produced). Production of a thirteen part series of half hour programs on women's issues (health, education, divorce, abuse, aging, etc.). Production and distribution of posters, brochures, calendars, etc.
• Service quality. Training of over 900 physicians in contraceptive technology and clinical breast examination. Training of 1,500 pharmacists in contraceptive technology. The first nation-wide quality assurance (QA) program for clinical pharmacology. The first nation-wide QA program for general practitioners.
• Domestic violence. A program for university students on domestic violence that included training and community activism by the trained students. In-home counseling for 21,000 abused women. Educational materials distributed directly to 230,000 women.
• Early detection of breast cancer. Training of 250 female GPs in clinical breast examination. In-home training of 220,000 women in self-examination. Production of five television PSAs, brochures, calendars, etc. Supported further screening for 4,800 women.
• Research on media effectiveness, perceptions of contraceptive methods, quality of service in pharmacies and private clinics, and decision-making processes.

Results:

• Behaviors. Six percentage point increase (net of dropouts) in modern method contraception at the national level. Private commercial sector share of family planning market increased nine percent. Discontinuation rates declined by an average of one-third for all modern short-term family planning methods. Audience surveys found almost all studied PSAs were associated with pronounced changes in beliefs. Sales of condoms doubled.
• Service quality. Average compliance with standards of care rose from 17 percent to 69 percent in the 950 participating pharmacies. Average compliance with internationally accepted standards of care rose from 51 to 72 percent among the 680 participating physicians.
• Domestic violence. Twenty-one percent of women visited sought further assistance and protection from domestic violence.

• Breast cancer. Three-fold increase in knowledge of breast self-examination. Compliance with referrals for clinical examination increased to 94 percent. 108 malignancies discovered, only 37 percent in later stages (national rate of late stage discovery had been 70 percent).
• Six major policy changes were obtained to improve accessibility and quality of services.

QA Program Director, Ministry of Health of Indonesia, Health Project IV (96-99). Designed and directed the World Bank funded quality improvement project in five provinces.

Major components:

• Quality assurance. Designed and managed the national QA program for primary care facilities in five provinces. Standards of care developed and implemented for ANC, ARI, vaccination, management of diarrhea, management of malaria, TB, and family planning. Three years after initiation, 1,488 health centers participated in the program and coverage was growing at a rate of 50 percent per year. Approximately 9,000 health posts participated in selected parts of the program.
• Program management. Participated in renovation and construction of health facilities. Prepared specifications and tenders, assisted with evaluation of proposals, and monitored contractor performance.
• Training. Developed and implemented distance learning training program on clinical and quality assurance topics. Over 1,100 health workers participated in the first round of training.
• Designed and conducted research on patient satisfaction, health worker satisfaction and incentives, and facility accreditation.

Results:

• The QA program became the world's largest primary care QA program at the time.
• Average compliance with best practices rose from less than 30 percent to over 80 percent in all interventions (ANC, ARI, etc.) in all districts.
• Almost all health centers formed quality improving committees and applied a team-based approach to more complex problems. Seventy-nine percent of the problems selected were judged to be significant (if solved would improve health outcomes or operating efficiency).
• Poly-pharmacy reduced by 40 percent in the QA health centers.
• Client utilization of health facilities increased five percent per year faster in QA health centers than in non-QA health centers.
• Distance learning program exceeded all targets (participation, pass rate, and cost).

Quality Assessment Project Field Director, Pakistan (89). Directed a project to assess quality of primary health care and effectiveness of community outreach in two provinces, Punjab and NWFP.

Major components:

• Development and acceptance of research protocols for assessing compliance with standards for ANC, vaccination, management of diarrhea and management of ARI.
• Direct observation of care in 53 health facilities. In-home survey of 1,300 women.

Results:

• Revision of procedures, increased supervision, and added training for staff in NWFP.

Producer, Public Television Series, *Computer BASICs* (82-84). Conceived, produced, scripted and hosted a 16 program series on computer programming and use of popular ap-

plications. Complete educational package available in Georgia; series was broadcast by PBS affiliates in seven other states. Further description below.

Producer, Public Television Series, *Global Enterprise* (81-82). Conceived, produced and hosted an interview-based series of 11 programs on international economic and business issues. Interviews conducted in five countries. Broadcast by PBS affiliates in 17 states; viewership in Georgia alone was over one million. Further description below.

Project Director, Population Programs Strengthening Project, Central America (74-76). Ford Foundation funded research, training and consulting project to strengthen management of public sector and NGO population programs in Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica and Panama. Joined project as researcher in 73 and assumed directorship in 74.

Major components:

- Research. Case studies and teaching cases developed on common management problems. Twenty-nine major cases produced in all six countries.
- Training. Three and four day seminars held for management teams of the six national programs. Seventeen seminars conducted.
- Consulting. Major interventions in Guatemala on program service strategy, Nicaragua on program norms, and El Salvador on organizational design.

Results:

- Following policy changes instituted: Fees for services, community distribution, reduced screening requirements for contraceptive adopters, IUD insertion by nurse/midwives, de-centralization of management functions.
- Management style. Anecdotal reports of more proactive management by program participants after completion of training, all countries except Panama.

Program Director, Rural Cooperative Strengthening Project, Nicaragua (74-76). An IDRC (Canada) funded project to strengthen the management of peasant marketing cooperatives. Principal activities were a survey of attitudes and management style of the coop's leadership and discussions of results in workshops with members and elected leaders.

Acting Program Director, Master of Public Sector Management, Instituto Centroamericano de Administración de Empresas (75-76). Ford Foundation provided seed money for a masters program in public management. Dr. Bernhart was the acting director for the first year of the program. Principal activities included development of teaching cases, three day seminars for senior officials, and development and presentation of courses for inclusion in the degree program when launched two years later. Major seminars were offered in Costa Rica at which the Vice-President and cabinet of the country participated for two days, and Panama where senior officials from all line Ministries attended a series of four weekend seminars.

Publications on Program Management

Sustainability: An Organizational Assessment. World Bank/OED. July 1996.

"Management of community distribution programs in Bangladesh" (with G.M. Kamal), *Studies in Family Planning*. July/August 1994.

"Strategic management of population programs," Policy Research Working Paper Series 996, World Bank, Washington, DC, 1992.

"Operations Research and Family Planning Management," in *Operations Research: Helping Family Planning Managers do Better*, M. Seidman (ed.) Wiley-Liss, New York, 1991.

"Islam and family planning acceptance in Bangladesh" (with M. Moslehuddin), *Studies in Family Planning*. September/October 1990.

"Organization decision-making and strategy formulation: application of a model," in *Advances in Health Care Research*, S. Smith and M. Venkatesan (eds.). Brigham Young University, 1984.

Management Development Exercises: Problem Solving Processes (with O. Quintana), Association of University Programs in Health Administration. Washington, DC, 1981.

Health Management Appraisal Methods: Jordan Case Study, Association of University Programs in Health Administration. Washington, DC, 1981.

"Using model projects to introduce change into family planning programs," *Studies in Family Planning*. October 1981.

New Methods for Assessing Developing Country Health Services Management Needs, Association of University Programs in Health Administration. Washington, DC, 1979.

"Logistics management in public health: the developing country experience," *Health Care Management Review*. Summer 1978.

"La implementación de cambios gerenciales en servicios de planificación familiar," in *Población y Gerencia*, Henry Gomez (ed.). Instituto de Estudios Superiores Administrativos, 1977.

QUALITY IMPROVEMENT

Dr. Bernhart has made contributions to quality improvement programs, having directed the programs in Indonesia, Jordan, Cambodia and Pakistan described above, taught QI in formal academic programs, consulted widely, and published on the topic.

Experience in Quality Improvement

QA Program Director, Ministry of Health of Indonesia, Health Project IV (96-99). Designed and directed the World Bank funded quality improvement project in five provinces as described above.

World Bank (94-95). Conducted pilot project on standards-based QI approach in two Indonesian provinces, East Java and Nusa Tenggara Barat. Led to loan and major QI program.

Keele University, UK (92-93). Designed and taught QI module in Masters course for developing country health program managers.

Ministry of Health, Chile (91). Consultant (to URC), participating in the design and introduction of the national QA program. Conducted research, developed teaching cases, taught in seminars, provided consultancies.

QA Project Field Director, Pakistan (89). Designed and conducted a service quality assessment of primary care services in two provinces as described above.

Publications on Quality Improvement

"The Indonesian Quality Assurance Program in Primary Health Care" (with Haryoko Wihardjo, and I.G.P. Wiadnyana. 17th International Conference of the International Society for Quality in Health Care. Dublin, 13-16 September 2000.

"Patient satisfaction in developing countries" (with I.G.P. Wiadnyana, Haryoko W., and I. Pohan), *Social Science & Medicine*, March 1999.

"Distance Learning in Quality Assurance for Health Workers." (With Dr. Azrul Azwar). Paper presented to the Fifth Symposium on Open and Distance Learning. "Improving Workforce Productivity." Surabaya, Indonesia. 29 November - 2 December 1999.

Quality Assurance (Jaminan Mutu): A Textbook. Open University Press. Jakarta, 1998.

"Training materials," in *Quality Assurance in Health Care*, World Health Organization, New Delhi, 1998.

"Teaching Quality Assurance through a Computer Simulation," in *International Journal of Adult Computer Education and Training*, no. 33, winter 1993.

TRAINING AND EDUCATION

Dr. Bernhart has been an innovator in training and education. He produced award-winning educational television series, was among the first to use computers for training health care providers in developing countries, and designed and implemented a successful distance-learning program.

University Teaching

Associate Professor of Management, University of Puget Sound, Tacoma, Washington (88-92, 93-96). Taught undergraduate classes in general management, public policy, strategy and international management. Conducted research and consulted on primary health care.

Visiting Scholar, Keele University, Keele, England, and visiting lecturer, **London School of Economics** (92-93). Taught management, quality assurance, and marketing to developing country health program managers in graduate programs at Keele. Taught principles of national health insurance to graduate students at London School of Economics.

Visiting Professor of Management, Organization, and Personnel, Nijenrode (The Netherlands School of Business), Breukelen, Holland (85-86). Taught graduate and undergraduate courses in marketing, strategy, management, and social policy.

Associate Professor of Management and Member of the Institute of International Business, Georgia State University, Atlanta, Georgia (76-85). Taught graduate and undergraduate classes in international management, research methods, strategy and management. Conducted research on cross-cultural management of organizations.

Assistant Professor, Instituto Centroamericano de Administración de Empresas (INCAE), Managua, Nicaragua (73-76). Taught graduate courses in organizational behavior and social policy. Acting Director of Masters Program in Public Management.

Educational Television

Computer BASICs (84). The rapid spread of personal computers led to widespread demand for knowledge in their use. Dr. Bernhart produced, scripted, and hosted a sixteen broadcast educational series on computer programming. The series introduced an innovative "hands-on" concept in educational television: viewers received laptop computers to practice programming while following televised instruction. A toll-free hotline allowed students to ask for personal assistance and two half-day classes were offered throughout the region for additional direct interaction with instructors. The series received awards for excellence and innovation in educational programming.

Global Enterprise (82). The early 80s saw increasing demand for information on the global economy. Dr. Bernhart produced and hosted an eleven program series for public television. Taping was conducted in five countries and the interviewees covered a broad range: prime minister, laborers, dissidents, investors, etc. Series nominated for Champion Award.

Computer Assisted Training

Quality Assurance: Theory and Practice. Open University, Jakarta. (99). A ten module program packaged with other distance learning materials that provided practical (virtual) experience in applying quality improving concepts.

Integrated Management of Childhood Illness with James Heiby and Jane Zucker (first release 94 through University Research Corporation, subsequent adaptations by Johns Hopkins University). This was a comprehensive training program on WHO's IMCI algorithm. Field tests in Uganda and Kenya showed the CAT program equaled the conventional WHO in-class training regarding skills and knowledge acquired, and cost one-third less per participant.

Quality Assurance: A Simulation, with James Heiby. University Research Corporation, Bethesda, MD (93). Simulates a third world health care facility where the student must identify and resolve problems in service quality.

Sustainability: An Organizational Assessment. World Bank/OED (96). A self-scoring assessment of the long-term prospects of a health care organization.

Business<=>Society. The player is placed in the role of general manager of a small US manufacturing firm who must deal with issues arising from the immediate business environment. Used with business management students.

Values Orientation. FRK Center for the Study of Values, Bellingham, WA (95). A computerized adaptation of the Kluckholn survey of culture-free orientations. Teaching as well as research versions were developed. Used primarily in cultural self-assessment and training activities by FRK.

Distance Learning

Quality Assurance: Theory and Practice. Open University, Jakarta. (99). With the CAT programs referenced above, a 6-8 week course for health care providers in Indonesia. Over 90 percent of the eligible health workers – 1,117 – completed the course. A difficult final examination was set and 89 percent passed. The cost per trainee was US$18. This was the most successful distance learning program in Open University's experience.

Computer BASICs (84). As described above.

Executive Management Teaching

Program designer and lead instructor in over 100 short-course training activities. The following illustrate the range of content and participants:

- Public sector. Vice-president and cabinet ministers, Costa Rica; strategic management and policy formulation in the public sector. Vice-ministers and division chiefs, Panama; strategic management in the public sector. Research directors, Bangladesh; qualitative research methods. Research directors, Indonesia; qualitative research methods. Economists and government policy makers, Colombia: export promotion.
- Public sector health. Minister of Health and division directors, Jordan; the impact of population growth on national development. Senior managers, Ministry of Health, Indonesia; quality assurance principles and methods. Senior health program officials, ten Southeast Asian countries; quality assurance. Minister of Health and division directors, Jordan; strategy and structure, role of management. Program directors, public health, Nicaragua; management information systems, supervision. Hospital directors and accountants, Jordan; financial control. Program directors, family planning, Asia and Africa; quality assurance. Program directors, Ministry of Health, Pakistan; quality assurance. Senior and mid-level managers, Ministry of Health, Indonesia; quality assurance. Division and program directors, Ministry of Health, Chile; quality assurance. Senior regional managers, Ministry of Health, Chile; quality assurance.

• Non-profit health. Program directors, family planning, Guatemala; organizational analysis and strategy. Program directors, family planning, Central America; role of manager, management information, supervision.
• Educators. Faculty of dentistry, Colombia; achievement motivation. Public school system officials, US; achievement motivation. Medical school administrators and faculty, Colombia; psychological education.
• Non-profit. Cooperative directors, Nicaragua; strategic planning.
• Private commercial sector. Japanese managers, US; international trade issues. Advanced management program, Central America; module on organization. International insurance managers, US; international political environment. Senior managers, various manufacturing enterprises, Yugoslavia; strategic management in an opening economy. Management group, electronics firm, US; organization and motivation. Directors and senior managers, retail chain, Colombia; personnel planning and management, Senior private sector managers, Guatemala; organizational structure and strategy.

Publications on Training

"Distance Learning in Quality Assurance for Health Workers" with Dr. Azrul Azwar. Paper presented to the Fifth Symposium on Open and Distance Learning. "Improving Workforce Productivity." Surabaya, Indonesia. 29 November - 2 December 1999.

Quality Assurance (Jaminan Mutu): A Textbook. Open University Press. Jakarta, 1998.

"Training materials," in *Quality Assurance in Health Care*, World Health Organization, New Delhi, 1998.

"Computer assisted data collection," in *User's Manual for the Value Orientations Method*, Kluckholn Center for the Study of Values, Seattle, 1995.

"Teaching Quality Assurance through a Computer Simulation," in *International Journal of Adult Computer Education and Training*, no. 33, winter 1993.

Management Development Exercises: Problem Solving Processes, with O. Quintana. Association of University Programs in Health Administration, Washington, DC, 1981.

RESEARCH

Dr. Bernhart has maintained an active interest in research methodologies throughout his career and has employed a wide variety of quantitative and qualitative methods as appropriate to the research question. As a Senior Scientist on URC's Family Planning Operations Research Project in Asia (resident in Bangladesh 86-88) Dr. Bernhart supervised operations research in Nepal, Bangladesh, Pakistan and Sri Lanka.

Publications on Research Methods

"Perceptions of contraceptives in Jordan." *Under review.*

"Patient satisfaction in developing countries" (with I.G.P. Wiadnyana, Haryoko W., and I. Pohan), *Social Science & Medicine*, March 1999.

"Computer assisted data collection," in *User's Manual for the Value Orientations Method*, Kluckholn Center for the Study of Values, Seattle, 1995.

"Attitudes of industrial workers in three Latin American societies: convergence, divergence, or accommodation?" (with C. Christensen), *Proceedings*, Rocky Mountain Council on Latin American Studies, 1983.

New Methods for Assessing Developing Country Health Services Management Needs, Association of University Programs in Health Administration, Washington, DC, 1979.

"Credibility of cross-national survey research data: an exploration using data from Puerto Rico, Venezuela, and Mexico," *Proceedings*, Rocky Mountain Council on Latin American Studies, 1978.

DONOR EXPERIENCE

Dr. Bernhart has worked with major donors, as a consultant, employee and contractor.

Work Experience

Global Fund to Fight AIDS, Tuberculosis, and Malaria. (Ongoing). Member of the Support Group, **Technical Review Panel**. Member of the **CCM/Cambodia** and CCM Subcommittee (07-08).

USAID. Directed Health Systems Strengthening project in Cambodia (07 – 08). Health Advisor, USAID/Azerbaijan (06-09/2006). Directed CMS and PSP projects in Jordan (99-05). Consultant to Missions in El Salvador (82), Guatemala (77-80), Dominican Republic (90, 93), Thailand (86), Bangladesh (86), Jordan (80-81), and Population Office/W (77, 80, 86).

World Bank. Consultant, proposal preparation, Cambodia. Consultant, health program management, Irian Jaya, Indonesia (99). Technical Advisor to Health Project IV/Indonesia (96-99). Consultant to pre-project pilot in two provinces in Indonesia (94-95). Developed sustainability assessment tool (96). Authored monograph on strategic management of population programs (92).

World Health Organization. Conducted two-week QI program for health managers from Asia and Africa (98). Consultancy to Zimbabwe population program (93).

IPPF/W. Consultant on organization design and management problems to affiliates in Central America (76-81).

Publication on Technical Assistance

"The preparation of technology transfer agents," in *International Communication of Technology*, Richard D. Robinson (ed.), Baylor and Francis, New York, 1991.

EDUCATION

Doctor of Philosophy, **Massachusetts Institute of Technology**, Int'l Management, 1977.

Master of Science, **Massachusetts Institute of Technology**, Int'l Management, 1970.

Bachelor of Arts, **Brown University**, Political Science, 1963.

Languages. Proficient in Spanish. Proficient in French and Bahasa Indonesia in the past and would expect to regain that with exposure and practice.

ANNEX D: BIBLIOGRAPHY OF DOCUMENTS COLLECTED/REVIEWED

"Ministry of Health Institutional Development Plan." Palestinian Health Sector and Development Project. March 2009.

"Ministry of Health System Assessment Report." Palestinian Health Sector and Development Project. December 2008.

Public Health Law. Palestinian Legislative Council. April 23, 2005

"National Strategic Health Plan, Medium Term Development Plan (2008- 2010)." Palestinian National Authority, Ministry of Health, Health Planning Unit. January 2008.

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Mary Segall. "Guidelines for accreditation of continuing professional development for health professionals," Flagship Project. January 2009.

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